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Department of Health and Ageing

Guiding principles for medication management in residential aged care facilities

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INTRODUCTION

Most people in residential aged care facilities (RACFs) need to take medicines, and many take a number of different medicines for different health conditions. RACFs must support and often manage each resident's medicines needs, while ensuring safe medication management for all residents, including those moving between the RACF and other care settings or providers.

The term 'medicine' includes prescription and non-prescription medicines, and complementary health care products.¹

The *Guiding Principles for Medication Management in Residential Aged Care Facilities* builds on previous editions of guidelines developed under Australia's National Medicines Policy.¹ The policy aims to meet Australia's medication and related service needs, to achieve optimal health outcomes and economic objectives. One of the four central objectives of the policy is the Quality Use of Medicines (QUM).

The *Guiding Principles for Medication Management in Residential Aged Care Facilities* promote a QUM approach to medicines use and medication management in RACFs. A QUM approach means:

- selecting the best way of maintaining the resident's health and treating any illness, which may or may not include medicines;
- choosing suitable medicines if a medicine is considered necessary; and
- using those medicines safely and effectively.²

While medicines make a significant contribution to preventing and treating disease, increasing life expectancy and improving quality of life, they also have the potential to cause harm. It has been shown that inappropriate or incorrect use of medicines can have an adverse effect on health. QUM aims to maximise the benefits and minimise the risks of harm from the use of medicines.

Purpose and scope

The *Guiding Principles for Medication Management in Residential Aged Care Facilities* promotes safe, quality use of medicines and medication management in RACFs. It is intended to assist RACFs to develop, implement, and evaluate locally specific policies and procedures, support those involved in assisting residents, and support residents in the medication management process.

The Guiding Principles advocate a partnership and systems approach to achieve safe and quality use of medicines and medication management in RACFs. Partnership means engaging all stakeholders according to their roles and responsibilities in medication management. A systems approach means developing behaviours and an environment that supports QUM. Medicines use and medication management should be linked to the RACF's continuous quality improvement and risk management programs and supported by information and education strategies.

This document does not provide clinical practice guidelines for particular health conditions or procedures, nor is it intended to be used as accreditation standards or a comprehensive policy and procedure manual for services.

The Guiding Principles are based on current best practice and available evidence, and are intended to be applicable to all RACF residents and settings. Their application must take into account relevant national, state and territory legislation and regulation, profession-specific licensing, guidelines and standards, and aged care quality and accreditation standards and requirements.

Development of these Guiding Principles

This document is a revision of the *Guidelines for Medication Management in Residential Aged Care Facilities* (2002) published by the former Australian Pharmaceutical Advisory Council (APAC). An evaluation of the Guidelines, undertaken in 2007, showed that they were widely used, but required revision in certain areas to reflect contemporary contexts and practice.

Australia's Health P/L was engaged by the Department of Health and Ageing to review current evidence, policies and practice for medication management in residential aged care, and to consult with peak stakeholder organisations and samples of local users to develop this document. The requirements also included producing a supplementary guide for residents and carers, and advising on potential implementation and education strategies.

The review process involved consultation with over fifty peak organisations and experts involved in medication management in RACFs, analysis of relevant documents and published literature, and targeted consultations with local RACF providers, staff, visiting health care professionals, resident and carer representatives.

Australia's Health P/L was supported by an expert reference group who provided advice on the processes and products of the review. The project outcomes were overseen by the National Medicines Policy Committee.

Evidence for action

Research for this revision showed continuing change and development within the residential aged care sector in medicines use and medication management:

People are older and more frail when they enter residential aged care. Life expectancy is increasing and more people are being supported by outreach services to remain longer in their own homes. In 2010, 55% of those in permanent care were aged over 85 years and 48% of those in respite care were over 85 years.³

Residents' care needs are more complex. The prevalence of chronic conditions increases markedly with age, resulting in more complex care needs.⁴ For example, cardiovascular disease and dementia affect a significant proportion of RACF residents, and increasing numbers receive specialised services such as pain management, palliative care and end-of-life care. Residents in aged care facilities are prescribed significantly more medicines than people living independently.⁵

The use of multiple medicines by residents is common in RACFs, given their complex care needs. Sommers *et al* (2010) identified polypharmacy (defined as the concurrent use of five or more medicines) in 91.2% of the RACF residents in their study, with an average of 9.75 medicines per person.⁶

Polypharmacy is a significant risk factor for adverse medicines events and poor outcomes in medicines use.⁷ A study of RACFs in Victoria found one-third of medicine-related problems were caused by over-prescribing, including unnecessary medicines, duplication of therapy or inappropriate duration. Other causes of medicine-related problems included dosing errors, suboptimal monitoring, and under-prescribing.⁸

The use of 'high risk' medicines is common in RACFs given the incidence of conditions requiring use of these medicines.⁹ High risk medicines such as anticoagulants, insulin, chemotherapy agents, narcotics and sedatives require careful monitoring. Error rates are not necessarily higher than with any other medicines, but when problems occur, the consequences can be severe.

Movement of residents across care settings challenges continuity of medication management. Studies show that up to 9% of residents per year move between RACFs and other care settings.^{10,11} There are also increasing numbers of people using short-term transition care programs provided in RACFs after a hospital stay.

Commonly reported problems during these transitions include poor transfer of information, inadequate arrangements for continuing medicines supply, and the absence of an up-to-date medication chart. These can lead to medication errors such as missed or significantly delayed doses, problems accessing medication information and supply of suitably packed medicines on short notice.¹²

Staffing profiles are changing. There are decreasing numbers of registered and enrolled nurses in the sector and a corresponding increase in the number of unlicensed assistants in nursing/personal care workers (however titled).¹³ Medication-related tasks are increasingly delegated to these unlicensed workers.

Obtaining timely access to general practitioners continues to be a problem, for both individual resident care needs and facility-wide roles in medication management and quality improvement. RACFs in rural and remote areas face additional barriers in access to both general practitioners and pharmacists.^{14 15}

Nurse practitioners have an increasing role in aged care. In aged care settings, nurse practitioners have an increasing role in providing support and direction to registered nurses and enrolled nurses in managing the complex care needs of residents with chronic disease such as diabetes, respiratory conditions, urinary conditions, and cardiac disease, and providing timely intervention to prevent unnecessary admission to tertiary health care facilities.

The national Health Reform agenda¹⁶ is improving the coordination, efficiency and effectiveness of health care. Medicare Locals, Local Health Networks and Lead Clinicians Groups provide mechanisms for planning and delivering more effective care across settings and locations, including better coordination of hospital services with RACFs and other community-based services. The personally controlled electronic health record (PCEHR)¹⁷ will assist secure, electronic sharing of information on an individual's health care, including medicines information.

Other national initiatives include the medication safety program of the Australian Commission on Safety and Quality in Health Care (including the National Residential Medication Chart); prescriber and community information and education programs through NPS: Better Choices, Better Health; the national recognition of health professionals through the Australian Health Practitioner Regulation Agency; and aged care sector workforce development in the Caring for Older People program of Health Workforce Australia.

Pharmacy services to RACFs continue to develop. The Fifth Community Pharmacy Agreement (July 2010–June 2015) between the Australian Government and the Pharmacy Guild of Australia (5CPA) supports pharmacists to provide additional services relating to QUM in RACFs. These include ongoing support for residential medication management reviews (RMMR), and new funding and practice incentive payments for services that are provided by pharmacists and designed to enhance QUM. Such QUM services can include staff training and education, continuous improvement activities, participation in Medication Advisory Committees, and involvement in the development of policy and procedures, especially in relation to medication management concerns.^{18 19}

ROLES AND RESPONSIBILITIES IN MEDICATION MANAGEMENT

Residential aged care is provided by approved providers under the *Aged Care Act 1997*. Approved providers have obligations and responsibilities described in the Quality of Care Principles²⁰ and measured by the Residential Care Standards and Accreditation Standards²¹ set out in the Quality of Care Principles. Medication management forms part of the care provided under the Act, Principles and Standards.

The prescription, supply and administration of medicines is strictly regulated for individual and public safety and quality of care. Approved providers and their delegated managers and staff must comply with relevant legislation such as state and territory drugs and poisons Acts (however titled).

All regulated health professions (including pharmacists, medical practitioners, nurse practitioners, registered and enrolled nurses) are subject to national, state and territory legislation and regulation governing their professions, including their roles in medication management. Health professionals also have professional practice standards and guidelines, which further define and guide their care roles and responsibilities in the RACF setting.

Registered nurses are qualified and legally authorised to administer medicines under the *Health Practitioner Regulation National Law Act 2009* and relevant state/territory legislation and regulation. Enrolled nurses work under the direction and supervision of registered nurses. Under the *Health Practitioner Regulation National Law Act 2009*, all enrolled nurses may administer medicines except for those who have a notation on the register against their name that reads, '*Does not hold Board-approved qualification in administration of medicines*'.

In some jurisdictions, assistants in nursing/personal care workers (however titled) perform medication-related tasks. They must do so in accordance with state or territory legislation, regulation and RACF policy and procedures for delegation and supervision. While some may have vocational training in medication management, these staff are not bound by standards set by a licensing authority.

Residents in RACFs and their carers have both rights and responsibilities in health care, as described in the Australian Charter of Healthcare Rights,²² the Charter of Residents Rights and Responsibilities²³ and the *Carer Recognition Act 2010*.²⁴ The Statement for Australian Carers (Schedule 1 of the *Carer Recognition Act 2010*) specifically indicates at Principle 7 that carers should be considered as partners with other care providers in the provision of care, acknowledging the unique knowledge and experience of carers.

Medication management should be seen as part of the health care functions and services covered by the Charters and Statement. Aged care residents also have specific rights in medication management, with the *Aged Care Act 1997* providing for the resident to choose and appoint their own general practitioner and pharmacist.

In addition, consumer protections such as the *Privacy Act*²⁵ apply to personal information, for example as contained in a medication chart or on a medicine label. State or territory legislation and regulation may also apply, for example in the provision of advanced care directives, guardianship, enduring power of attorney or consent to treatment.

While all partners in medication management must comply with relevant legislation, regulations and standards, promoting QUM requires consideration of how each partner group can actively contribute and participate. The National Strategy for the Quality Use of Medicines² describes how consumers, health professionals and care facilities can contribute to QUM through specific responsibilities:

All partners are responsible for:

- improving medication use by recognising when and where problems exist;
- identifying factors that contribute to those problems, initiating interventions to improve medication use, and evaluating outcomes;
- enhancing understanding of the risk and benefits associated with the use of all medicines;
- fostering informed debate about the role of medicines in health care; and
- working in partnership to achieve quality use of medicines (QUM).

Health care consumers are responsible for:

- asking for and utilising objective information, resources and services to make decisions and take actions that enable medicines, when they are required, to be chosen and used wisely;
- becoming more aware of the risks and benefits of medicines, the possibility of non-drug options and the importance of a healthy life-style;
- developing skills and confidence to use medicines appropriately and seeking help to solve problems when they arise; and
- becoming more aware of the place of medicines in the broader context of health services and society.

Health practitioners and educators are responsible for:

- assisting people in making informed decisions and learning more about health issues and health care through information, education and discussion;
- becoming more aware of the risks and benefits of medicines, the possibility of non-drug options and the importance of a healthy life-style;
- utilising objective information, resources and services to make decisions and take actions that enable medicines, when required, to be chosen and used wisely;
- continually developing knowledge and skills to use medicines appropriately; and
- becoming more aware of the place of medicines within society.

Health and aged-care facilities are responsible for:

- providing facilities, systems, training opportunities and structures that support staff, health practitioners and consumers in using medicines wisely and that avoid medication errors.

Source: National Strategy for the Quality Use of Medicines (pp.10–11)

THE GUIDING PRINCIPLES

GUIDING PRINCIPLE 1. MEDICATION ADVISORY COMMITTEE

The RACF should establish (or have direct access to) and use a Medication Advisory Committee to support the safe and effective management and quality use of medicines in the facility.

GUIDING PRINCIPLE 2. INFORMATION RESOURCES

The RACF should ensure that current and accurate medicines information resources are available to all residents, carers, staff and visiting health care professionals.

GUIDING PRINCIPLE 3. SELECTION OF MEDICINES

The RACF should support informed and considered selection of all medicines used in the facility.

GUIDING PRINCIPLE 4. COMPLEMENTARY, ALTERNATIVE AND SELF-SELECTED NON-PRESCRIPTION MEDICINES

The RACF should support informed selection and safe use of complementary, alternative and self-selected non-prescription medicines used by residents.

GUIDING PRINCIPLE 5. NURSE-INITIATED NON-PRESCRIPTION MEDICINES

The RACF should develop policies and procedures for safe practice in nurse-initiation of non-prescription medicines.

GUIDING PRINCIPLE 6.
STANDING ORDERS

The RACF should develop policies and procedures to guide the use and review of standing orders where these are used in the facility.

GUIDING PRINCIPLE 7.
MEDICATION CHARTS

The RACF should ensure all residents have a current, accurate and reliable record of all medicines selected, prescribed and used, to support safe prescribing and administration of medicines and effective communication of medicines information between residents and their health care professionals, and between care settings.

GUIDING PRINCIPLE 8.
MEDICATION REVIEW AND MEDICATION RECONCILIATION

The RACF and residents' visiting health care professionals should ensure each resident's medication management is reviewed regularly and as needed. Medication reconciliation processes should be used to ensure residents receive all intended medicines, and to reduce risk of errors in documentation when care is transferred or new medicines are ordered.

GUIDING PRINCIPLE 9.
CONTINUITY OF MEDICINES SUPPLY

The RACF should ensure that medicines supply is maintained for residents in changed circumstances to reduce disruption of their access to needed medicines.

GUIDING PRINCIPLE 10.
EMERGENCY STOCK OF MEDICINES

The RACF should develop policies and procedures for the management of an emergency stock of medicines where this is used.

GUIDING PRINCIPLE 11.
STORAGE OF MEDICINES

The RACF should ensure all medicines, including self-administered medicines, are stored safely and securely and in a manner that maintains the quality of the medicine.

GUIDING PRINCIPLE 12.
DISPOSAL OF MEDICINES

The RACF should ensure that unwanted, ceased or expired medicines are disposed of safely to avoid accidental poisoning, misuse and toxic release into the environment.

GUIDING PRINCIPLE 13.
SELF-ADMINISTRATION OF MEDICINES

The RACF should support those residents who wish to administer their own medicines as part of maintaining their independence. This should follow assessment and regular review of these residents' capacity to self-administer medicines safely.

GUIDING PRINCIPLE 14.
ADMINISTRATION OF MEDICINES BY RACF STAFF

The RACF should ensure that staff are appropriately qualified and authorised to administer medicines, and that administration practices are monitored for safety and quality.

GUIDING PRINCIPLE 15.
DOSE ADMINISTRATION AIDS

The RACF should develop policies and procedures to guide dose administration aid needs assessment, preparation, use, monitoring and quality assurance.

GUIDING PRINCIPLE 16.
ALTERATION OF ORAL DOSE FORMS

The RACF should ensure that residents, their carers and staff administering medicines know which oral dose medicines can and cannot be altered in form, such as by crushing or chewing and any special conditions relating to the alteration or administration of specific medicines.

GUIDING PRINCIPLE 17.
EVALUATION OF MEDICATION MANAGEMENT

The RACF should regularly review and evaluate each area of medication management for outcomes and take follow-up action where required.

GUIDING PRINCIPLE 1.

MEDICATION ADVISORY COMMITTEE

The RACF should establish (or have direct access to) and use a Medication Advisory Committee to support the safe and effective management and quality use of medicines in the facility.

CONTEXT AND DEFINITION

Medication management in RACFs should operate within a safety and quality care framework and ensure that the rights and responsibilities of residents and their carers are taken into account.

Facilities need to have a mix of expert advice and skills that enables them to fulfil their roles and meet their responsibilities in medication management and achieve optimal outcomes for all residents.

A Medication Advisory Committee (MAC) is a group of advisors to the RACF who assist in the development, promotion, monitoring, review and evaluation of medication management policies and procedures that will have a positive impact on health and quality of life for residents.

MACs play a key role in the governance of medication management in RACFs and bring significant benefits through improved interdisciplinary communication, collaboration and understanding of the medication management process. They have been identified as a key strategy to advance the quality use of medicines (QUM) in RACFs.

The MAC:

- provides a multidisciplinary partnership approach to medication management, supports evidence-based practice, and provides a forum in which to raise policy and practice issues;
- represents all partners' views in medication management;
- ensures that residents' rights, including consent and privacy, are taken into account in medication management policy and practice;
- provides expert advice on legislative, regulatory and professional standards and requirements in relation to medication management;

- ensures a systematic overview of all aspects of medication management in the RACF;
- monitors, reviews and evaluates the safe and quality use of medicines and recommends any corrective action;
- reviews medication incidents, adverse drug reactions and adverse drug events and their reporting; and
- advises on information, education and training resources to assist medication management.

IMPLEMENTATION GUIDE

The RACF should establish (or have direct access to) and use a MAC to assist and advise in the development, promotion, monitoring, review and evaluation of medication management policies, procedures and outcomes.

The MAC should comprise representatives of RACF management, nurse/s, medical practitioner/s, pharmacist/s and residents. Where necessary, the MAC should consider obtaining the advice of other health professionals with expertise relevant to specific issues (e.g. geriatrics, physiotherapy, mental health, complementary and alternative medicines).

The MAC should operate under Terms of Reference approved by the RACF Board of Management, and be formally linked to the governance, management and continuing quality assurance structures and processes of the RACF.

The RACF should provide sufficient resourcing to enable the MAC to be effective and functional and the MAC should meet regularly to perform its functions.

Medicare Locals, Local Health Networks and pharmacy QUM services funded under the Fifth Community Pharmacy Agreement (5CPA) increase opportunities for both individual and regional network participation by health care professionals and facilities.

If RACFs experience difficulties in accessing volunteer members for MACs, one option that has been successful in some areas is a regional model, where groups of RACFs work with a single MAC. Telephone and/or video conferencing should be available to enable effective participation.

RESOURCES

The following section provides an example of the MAC role, Terms of Reference and meeting agenda.

EXAMPLE ROLE, TERMS OF REFERENCE AND MEETING AGENDA FOR A MEDICATION ADVISORY COMMITTEE

Role

Through a partnership approach, develop, promote, monitor, review and evaluate medication management policies and procedures to assist the RACF in the safe and quality use of medicines.

Terms of reference

1 Advise on legislation, standards and processes in medication management.

- Advise on the implementation of national standards, guidelines and policies and legislation relevant to medicines use in the residential aged care facility.
- Review the processes for timely, effective communication between prescribers, the pharmacist/s and the facility in accordance with legislative requirements.
- Advise on the development of an information technology strategy to support safe, quality medication management within the facility.

2 Advise on information and education needs and strategies to support quality use of medicines in the facility.

- Advise on appropriate medicines education programs for staff of the facility.
- Promote in residents and carers awareness of their rights and responsibilities with regard to their medication management.
- Develop mechanisms to provide information about medicines, including Consumer Medicine Information, to staff, residents and carers.

- Make recommendations on the medicines information and resources to be available at the facility.

3 *Advise on clinical issues and best practice in quality use of medicines.*

- Assist the facility to develop policies and performance indicators on medicines use, and to evaluate their implementation.
- Monitor and make recommendations on the use of medicines for specific health conditions and symptoms, for example behavioural and psychological symptoms of dementia, pain management, end-of-life care.
- Monitor and advise on the use of 'high risk' medicines such as those with a narrow therapeutic index or at risk of misuse or abuse.
- Monitor and advise on the management of any other clinical issues that arise involving the use of medicines.

4 *Advise on policies and procedures for effective medication management.*

- Assist the facility in developing, promoting, monitoring, reviewing and evaluating medication management policies and procedures in:
 - the use of complementary, alternative and self-selected medicines
 - nurse-initiated non-prescription medicines: list and practices
 - standing orders (where used in the RACF)
 - medication charts
 - medication review and reconciliation
 - continuity of medicines supply
 - emergency stock of medicines (where used in the RACF)
 - storage of medicines
 - disposal of medicines

- administration of medicines by RACF staff
- the use of dose administration aids
- alteration of oral dose forms: list and practices for medicines that cannot be altered (e.g. crushed or broken) prior to administration
- the use of ‘when required’ (PRN) medicines
- the administration of medicines for residents temporarily off site (e.g. excursion, temporary home visit).

5. Advise on evaluation and review of safe, quality medicines use and practices in the facility.

- Assist in the development and evaluation of indicators for quality use of medicines as part of the risk management and quality assurance framework of the facility.
- Make recommendations to the board or management of the facility on any matter relating to medicines use with the view of optimising health outcomes through the safe and quality use of medicines.
- Develop mechanisms for review and evaluation of:
 - medicines use across the facility compared to best practice guidelines (e.g. through use of Drug Use Evaluation activities)
 - the outcome of medication review processes (e.g. the use of Residential Medication Management Reviews)
 - medication errors and incidents
 - adverse drug reaction reporting to the national reporting system
 - the performance of dose administration aids, ensuring regular review for errors in labelling, packaging and administration.

Example of a MAC meeting agenda

(Name of facility and MAC) (Day, date and time of Meeting)

AGENDA:

- 1 Present
- 2 Apologies
- 3 Confirmation of previous minutes (date)
- 4 Action arising and ongoing
- 5 General business
 - 5.1 Legislation, standards and processes
 - 5.2 Information and education
 - 5.3 Clinical issues and best practice
 - 5.4 Policy and procedures
 - 5.5 Review, monitoring, reporting and follow up
- 6 New business
- 7 Close and date for next meeting

GUIDING PRINCIPLE 2. INFORMATION RESOURCES

The RACF should ensure that current and accurate medicines information resources are available to all residents, carers, staff and visiting health care professionals.

CONTEXT AND DEFINITION

In order to support quality use of medicines (QUM), residents, carers, RACF staff and visiting health care professionals need access to current and accurate information on medicines and their safe and effective use in the treatment and care of older people, including those with complex health conditions.

Residents and their carers need information to support decision-making about their medicines, informed consent, and the resident's own medication management. Staff and visiting health care professionals need information resources to support and guide their medication roles and responsibilities within their scope of practice.

Information resources relevant to medication management in RACFs include:

- information about particular medicines, such as Product Information and Consumer Medicines Information (CMI);
- information to assist residents in recording and/or self-administering their own medicines, such as medicines lists;
- information about the quality use of medicines for particular health conditions and groups, such as therapeutic and clinical guidelines;
- information on professional roles and responsibilities, such as medical, pharmacy or nursing practice standards and guidelines;
- information about the legislative and regulatory context, such as state and territory drugs and poisons Acts; and
- information about the RACF's medication management, such as policies, procedures, reporting, review and evaluation.

IMPLEMENTATION GUIDE

The RACF should ensure all residents, carers, RACF staff and visiting health care professionals have access to current and accurate information resources to support quality medication management for residents. Accessing and using medicine information resources should be considered as part of the RACF's quality assurance, education and information technology policies and practices.

Many information resources relevant to medicines use and medication management are now available on-line from government, professional, industry, consumer and carer organisations. This provides the opportunity to build a 'virtual library' of resources to enable ready access when needed. Some information resources may charge a fee to access, while others are in the public domain.

The MAC should assist RACF management and staff to identify, access and develop appropriate information resources. Under the Fifth Community Pharmacy Agreement, (5CPA), registered and accredited pharmacists can be funded to provide QUM education services to RACFs.

In ensuring effective use of information resources, RACFs need to consider how ready access is to be provided to different users, and after hours. Provision of information should take into account the health literacy, level of understanding of medicines information, language skills and cultural background of the person seeking the information.

RESOURCES

Examples of information resources relevant to medication management in RACFs are listed below. They are broadly grouped into: tools and information to support residents and carers; information resources about medicines, therapeutics and services to support QUM; and legislation, regulation and standards for aged care, health professions and medicines.

Entries are organised alphabetically. Other information resource links specific to a Guiding Principle topic are included in the 'Resources' section of each Guiding Principle. Unless shown otherwise, there is no purchase charge for the resource.

TOOLS AND INFORMATION TO SUPPORT RESIDENTS AND CARERS

Adverse Medicine Events Line

This is a service for the general public who suspect they have experienced an adverse medicines event. It is run by the Mater Hospital in Brisbane, which forwards reports to the TGA. Available Australia wide, Monday to Friday 9am–5pm AEST, for the cost of a local call. **Telephone 1300 134 237**

Consumer Medicines Information (CMI)

CMI is designed to inform consumers about prescription and pharmacist-only medicines. CMI provides accurate, unbiased and easy to use information on the safe and effective use of that medicine. CMI may be included in the medicine package, but can always be requested from the pharmacist or doctor, or online at: **www.ebs.tga.gov.au/** or **www.nps.org.au/search_by_medicine_name**

HealthInsite

A site backed by the Australian, State and Territory Governments, providing a gateway to a wide range of free, up-to-date and reliable information on health and wellbeing. **www.healthinsite.gov.au**

Medicines Line

Medicines Line provides consumers with accurate and up-to-date information about prescription, over-the-counter and complementary medicines. Experienced medicines information specialists and clinical pharmacists provide the information. Available Monday to Friday 9am–5pm AEST from anywhere in Australia for the cost of a local call (calls from mobiles may cost more). **Telephone 1300 633 424**

Medicines List

A free wallet-sized list produced by the NPS: Better Choices, Better Health to assist consumers to keep an up-to-date record of all medicines taken. **www.nps.org.au/consumers/tools_and_tips/medicines_list**

Medicines Talk

This free quarterly newsletter is produced by NPS: Better Choices, Better Health for consumers. It provides reliable, accurate information and useful hints on managing medicines, especially multiple medicines.

www.nps.org.au/consumers/publications/medicines_talk

MediList

MediList is produced by the Department of Veterans' Affairs to assist consumers to keep an up-to-date record of all medicines taken. The MediList form can be completed online and printed, and is also available from pharmacies.

www.dva.gov.au/health_and_wellbeing/self-management/Pages/MediList.aspx

Medimate

Medimate is a free brochure produced by NPS: Better Choices, Better Health to help consumers find, understand and use information about medicines. Medimate covers prescription, non-prescription and complementary medicines. Medimate is available in several community languages.

www.nps.org.au/consumers/tools_and_tips/medimate

RESIDENT AND CARER CHARTERS AND RIGHTS

Australian Charter of Healthcare Rights

Everyone who is seeking or receiving care in the Australian health system has certain rights regarding the nature of that care. The Australian Charter of Healthcare Rights spells out these rights.

www.safetyandquality.gov.au/publications/australian-charter-of-healthcare-rights-the/

Charter of Residents' Rights and Responsibilities

This Charter (located in the User Rights Principles 1997) under the *Aged Care Act 1997*, spells out the rights and responsibilities of residents in RACFs.

www.comlaw.gov.au/Details/F2012C00077

Statement for Australia's Carers

Established under the *Carer Recognition Act 2010*, the Statement establishes how carers should be treated and considered by Commonwealth agencies and persons or bodies that are contracted or funded by these agencies to develop, implement, provide or evaluate care supports. The Statement is available at:

www.carersaustralia.com.au/?/article/view/1991

INFORMATION RESOURCES ABOUT MEDICINES, THERAPEUTICS AND SERVICES TO SUPPORT QUM

Adverse Drug Reaction Reporting

Residents and healthcare professionals are encouraged to report any suspected adverse reaction to a prescription, non-prescription or complementary medicine to the Therapeutic Goods Administration (TGA). These reports can be made using:

- **The Blue Card Adverse Reaction Reporting Form**

This is available for completion and downloading for submission by post, fax or email from

www.tga.gov.au/safety/problem-medicines-forms-bluecard.htm

- **Australian Adverse Drug Reaction Reporting System**

This is an online reporting system available at

www.ebs.tga.gov.au/ebs/ADRS/ADRSRepo.nsf?OpenDatabase

Australian Drug Information for the Health Care Professional (AusDI)

AusDI is a comprehensive source of medicine and therapeutic information, including the most commonly used complementary health care products.

Available for purchase at: www.phoenixmedical.com.au

Australian Medicines Handbook (AMH)

The AMH provides readily accessible, concise, current, independent medicines information to facilitate effective, rational, safe and economical prescribing.

Available for purchase at: www.amh.net.au

AMH Drug Choice Companion: Aged Care

This publication contains independent drug information that promotes quality use of medicines in older Australians. It contains information on more than 70 specific conditions common in older people. Available for purchase at: www.amh.net.au/

Australian Pharmaceutical Formulary and Handbook

This publication is designed to assist pharmacists to promote optimal health outcomes through the quality use of medicines. It provides core information on therapeutics and standards of practice. Available for purchase at: www.psa.org.au

Australian Prescriber

This is a free, independent publication providing readily accessible information about medicines and therapeutics published by the NPS: Better Choices, Better Health. It covers topics for health professionals, students and consumers. Available at: www.australianprescriber.com

Medicines Safety Update and Therapeutic Goods Administration (TGA) safety alerts

Medicines Safety Update appears in each edition of Australian Prescriber and on the TGA website. It provides information and advice on drug safety and emerging safety issues. It is available at: www.tga.gov.au/hp/msu.htm

MIMS Annual

This reference classifies medicines by therapeutic class. It contains complete, detailed, approved prescribing information for prescription and non-prescription medicines. Available for purchase at: www.mims.com.au

National Medicines Policy

The Policy is a cooperative endeavour to bring about better health outcomes for all Australians, focusing particularly on people's access to and wise use of prescription, non-prescription and complementary medicines. It is available at: www.health.gov.au/nationalmedicinespolicy

Natural Medicines Comprehensive Database

This is a database providing complementary and alternative medicines information, available for subscription purchase at:

<http://naturaldatabase.therapeuticresearch.com/home.aspx?cs=&s=ND&ASpxAutoDetectCookieSupport=1>

National Poisons Information Centre

The National Poisons Information Centre is available Australia-wide, 24 hours a day for the cost of a local call. **Telephone 131 126**

National Institute of Complementary Medicine (NICM)

NICM was established to provide leadership and support for strategically directed research into complementary medicine and translation of evidence into clinical practice and relevant policy to benefit the health of all Australians. **www.nicm.edu.au**

NPS Rational Assessment of Drugs and Research (RADAR)

NPS RADAR is published by NPS: Better Choices, Better Health. It provides free, independent, evidence-based assessment of new medicines, new PBS listings and the latest research for healthcare professionals. It is available at:

www.nps.org.au/health_professionals/publications/nps_radar

National Strategy for Quality Use of Medicines (QUM)

The National Strategy for QUM is part of the National Medicines Policy. The Strategy describes the range of partnerships and the breadth of activities required to make the best possible use of medicines to improve health outcomes for all Australians.

www.health.gov.au/internet/main/publishing.nsf/Content/nmp-pdf-natstrateng-cnt.htm

Product Information (PI)

PI provides a TGA-approved summary of the essential scientific information for the safe and effective use of a prescription medicine. This includes objective information about the medicine's quality, safety and effectiveness. Available at:

www.ebs.tga.gov.au/

Quality Use of Medicines (QUM) services

These are additional services provided to RACFs by pharmacists, such as medication advisory activities, education and continuous improvement. These QUM services are funded under the Fifth Community Pharmacy Agreement (July 2010–June 2015) between the Australian Government and the Pharmacy Guild of Australia (5CPA).

Information on the QUM services funded under 5CPA can be found at:

www.medicareaustralia.gov.au/provider/pbs/fifth-agreement/quality-use-of-medicines.jsp

Residential Medication Management Review (RMMR)

RMMR is a service provided to permanent residents of an Australian Government funded aged care facility, and those permanent residents in flexible care arrangements (transitional care facilities). RMMR is funded under 5CPA. Information about the RMMR can be found at: **www.medicareaustralia.gov.au/provider/pbs/fifth-agreement/residential-medication-management-review.jsp**

- The Pharmaceutical Society of Australia *Guidelines for RMMR* is available at: **<http://www.psa.org.au/download/practice-guidelines/rmmr-and-qum-services.pdf>**
- The Medical Benefits *Schedule Items for RMMR* are available at: **www.health.gov.au/internet/main/publishing.nsf/Content/medication_management_reviews.htm**

Therapeutic Guidelines

Therapeutic Guidelines provide clear, concise, independent and evidence-based therapeutic information and recommendations on patient management, based on the latest literature. Available for purchase at: **www.tg.org.au**

LEGISLATION, REGULATION AND STANDARDS IN AGED CARE, HEALTH PROFESSIONS AND MEDICINES

AGED CARE LEGISLATION, REGULATION AND STANDARDS

Aged Care Act 1997

This Act governs all aspects of the provision of residential care, flexible care and Community Aged Care for older Australians, including matters relating to the planning of services, the approval of service providers and care recipients, payment of subsidies, responsibilities of service providers, accreditation, quality of care principles, and residents' rights and responsibilities. Available at: www.comlaw.gov.au/Details/C2012C00139

Aged Care Accreditation Standards

Under the *Aged Care Act 1997*, the Accreditation Standards specify the requirements for the quality of care against which all RACFs must be assessed in order to receive funding from the government. Information about the Accreditation Standards can be found at: www.accreditation.org.au/accreditation

Quality of Care Principles 1997

Under the *Aged Care Act 1997*, the Quality of Care Principles outline the responsibilities of residential and community aged care facilities relating to the quality and accountability of the care they provide; requirements for compliance with, and respect for the rights of residents; and the basic suitability of their key personnel. The Quality of Care Principles are available at: www.comlaw.gov.au/Details/F2011C00126/Html/Text#_Toc285788744

HEALTH PROFESSIONS LEGISLATION AND REGULATION

Australian Health Practitioner Regulation Agency (AHPRA)

AHPRA is responsible for the implementation of the National Registration and Accreditation Scheme for the health professions regulated in Australia under the *Health Practitioner Regulation National Law Act 2009*. www.ahpra.gov.au

Health Practitioner Regulation National Law Act 2009

This Act (as in force in each jurisdiction) established the National Registration and Accreditation Scheme for all health practitioners and students undertaking programs of study leading to registration as a health practitioner. This Act is available at: www.austlii.edu.au/au/legis/qld/consol_act/hprnla2009428/

HEALTH PROFESSIONAL STANDARDS AND GUIDELINES

Health professional organisations may publish standards and/or guidelines relevant to their professions' roles in aged care services. See for example:

- **Nursing:** Australian Nursing Federation and the Royal College of Nursing Australia. *Nursing Guidelines for Medication Management in Aged Care*. www.anf.org.au/html/publications_reports.html
- **Pharmacy:** Pharmaceutical Society of Australia. *Professional Guidelines*. www.psa.org.au/supporting-practice/guidelines; and the *Professional Practice Standards*. www.psa.org.au/supporting-practice/professional-practice-standards
- **Medical Practitioners:** Royal Australian College of General Practitioners. *The Medical Care of Older Persons in RACFs—the Silver Book*. www.racgp.org.au/guidelines/silverbook

NATIONAL MEDICINES LEGISLATION AND REGULATION

Medicines Classification in Australia

In Australia, medicines are classified into three categories: Registered Medicines, Listed Medicines, and Complementary Medicines. An overview of the classification system can be found at:

www.tga.gov.au/industry/regulation-basics-medicines-classifications.htm

Standards for the Uniform Scheduling of Medicines and Poisons (SUSMP)

SUSMP ('The Poisons Standard') is a record of the classification of medicines and chemicals into Schedules and includes provisions regarding containers and labels, and recommendations about other controls on medicines and chemicals. It is available at: www.tga.gov.au/industry/scheduling-poisons-standard.htm

Therapeutic Goods Act 1989

The Therapeutic Goods Act sets out the legal requirements for the import, export, manufacture and supply of therapeutic goods in Australia. It details the requirements for listing, registering or including medicines, medical devices and biological products on the Australian Register of Therapeutic Goods (ARTG), as well as other aspects such as advertising, labelling, and product appearance. The Act is available at:

www.austlii.edu.au/au/legis/cth/consol_act/tga1989191/

STATE AND TERRITORY DRUGS AND POISONS LEGISLATION AND REGULATION

The following is a list of the title and web address for primary legislation dealing with drugs, poisons, and medication administration for each state and territory.

The legislation can also be found at the Australasian Legal Information Institute website at: **www.austlii.edu.au**

Australian Capital Territory

Medicines, Poisons and Therapeutic Goods Act 2008.

www.legislation.act.gov.au/a/2008-26/default.asp

Medicines, Poisons and Therapeutic Goods Regulation 2008.

www.legislation.act.gov.au/sl/2008-42/default.asp

New South Wales

Poisons and Therapeutic Goods Act 1966 No 31.

www.legislation.nsw.gov.au/viewtop/inforce/act+31+1966+FIRST+0+N/

Poisons and Therapeutic Goods Regulation 2008.

www.legislation.nsw.gov.au/viewtop/inforce/subordleg+392+2008+FIRST+0+N/

Northern Territory

Poisons and Dangerous Drugs Act and Regulations. All current consolidated Acts and subordinate legislation of the Northern Territory of Australia can be found at:

http://dcm.nt.gov.au/strong_service_delivery/supporting_government/current_northern_territory_legislation_database

Queensland

Health Act 1937.

www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealA37.pdf

Health (Drugs and Poisons) Regulation 1996.

www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealDrAPoR96.pdf

Health Regulation 1996 (Part 4—Dispensary and Part 16—Therapeutic Goods and Other Drugs): www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealR96.pdf

South Australia

Controlled Substances Act 1984 (SA).

www.legislation.sa.gov.au/LZ/C/A/CONTROLLED%20SUBSTANCES%20ACT%201984/CURRENT/1984.52.UN.RTF

Controlled Substances (Poisons) Regulations 1996 (SA).

[www.legislation.sa.gov.au/LZ/C/R/Controlled%20Substances%20\(Poisons\)%20Regulations%202011.aspx](http://www.legislation.sa.gov.au/LZ/C/R/Controlled%20Substances%20(Poisons)%20Regulations%202011.aspx)

Tasmania

Poisons Act 1971.

www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=81%2B%2B1971%2BAT%40EN%2B20100512100000;hison=;prompt=;rec=;term

Poisons Regulations 2008.

www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=%2B162%2B2008%2BAT%40EN%2B20100512100000;hison=;prompt=;rec=;term

Victoria

Drugs, Poisons and Controlled Substances Act 1981.

Drugs, Poisons and Controlled Substances Regulations 2006.
www.legislation.vic.gov.au/

Western Australia

Poisons Act 1964.

www.slp.wa.gov.au/legislation/statutes.nsf/main_mrtitle_728_homepage.html

Poisons Regulation 1965.

www.slp.wa.gov.au/legislation/statutes.nsf/main_mrtitle_1920_homepage.html

GUIDING PRINCIPLE 3. SELECTION OF MEDICINES

The RACF should support informed and considered selection of all medicines used in the facility.

CONTEXT AND DEFINITION

The decision to select and use a medicine in a RACF may occur at several points:

- the resident or carer may select a non-prescription, complementary or alternative medicine;
- a person authorised to prescribe medicines may order a medicine for the resident within their scope of practice and prescribing authority; and
- an authorised and qualified nurse may initiate a medicine from a pre-approved list or order.

In supporting informed and considered selection of medicines, the RACF should take a quality use of medicines (QUM) approach.² This involves:

- selecting management options wisely, including consideration of non-medicine alternatives;
- choosing suitable medicines if a medicine is considered necessary; and
- using medicines safely and effectively to get the best possible results.

IMPLEMENTATION GUIDE

Processes for the selection of medicines used in the facility should reflect a QUM approach. They should promote partnership and shared responsibility by all involved, to achieve optimum health benefits for residents.

The RACF should develop medication management policies and procedures for the selection of medicines in consultation with the MAC. Policy and procedures should recognise:

- the range of health professionals with prescribing rights (for example medical practitioners, nurse practitioners, dentists, podiatrists and optometrists);
- selection of medicines by nurses from pre-approved lists and protocols (e.g. nurse-initiated medicines lists, standing orders); and
- self-selection of medicines including non-prescription, complementary and alternative medicines by residents and/or their carers.

There may also be particular issues for medication management in the presence of conditions such as diabetes, dementia, behavioural disturbances, falls, or incontinence, or for residents requiring end-of-life or palliative care. Under a QUM approach, the RACF should consider strategies to support both effective medicines use and non-medicine alternatives.

The RACF medication management policies and procedures should promote the use of appropriate evidence-based references by all those selecting medicines (e.g. therapeutic guidelines for prescribers, and Consumer Medicines Information for residents)—see Guiding Principle 2: Information Resources.

Selection of medicines is assisted by effective communication between care team members, residents and their carers/representatives, and accurate and reliable records such as medication charts, laboratory results and adverse drug reaction history.

Medicine reviews for individual residents (such as Residential Medication Management Reviews), and assessing medicines use and practice at the facility level by methods such as Drug Use Evaluation can help to reduce inappropriate use of medicines. These practices can also facilitate a multidisciplinary approach to quality improvement, provide information and feedback to staff, management and the MAC, and promote compliance with Accreditation Standards.

RESOURCES

- *The National Strategy for Quality Use of Medicines*.
www.health.gov.au/internet/main/publishing.nsf/Content/nmp-pdf-natstrateng-cnt.htm
- *Drug Use Evaluation for Aged Care Facilities*. NPS: Better Choices, Better Health.
www.nps.org.au/health_professionals/drug_use_evaluation_due_programs/due_kit_for_care_homes
- *Medicines safety updates*. Therapeutic Goods Administration.
www.tga.gov.au/hp/msu.htm

GUIDING PRINCIPLE 4. COMPLEMENTARY, ALTERNATIVE AND SELF-SELECTED NON-PRESCRIPTION MEDICINES

The RACF should support informed selection and safe use of complementary, alternative and self-selected non-prescription medicines used by residents.

CONTEXT AND DEFINITION

Complementary and alternative medicines (CAMs) and non-prescription medicines are widely available and used in the Australian community. They are generally available for self-medication by consumers and can be obtained from retail outlets.

CAMs include herbal, vitamin and mineral products, nutritional supplements, homeopathic medicines, traditional Chinese medicines, Ayurvedic medicines, Australian Indigenous medicines, and some aromatherapy products regulated under the *Therapeutic Goods Act 1989*. Other terms sometimes used to describe CAMs include 'natural medicines' and 'holistic medicines'.

Examples of non-prescription medicines include cough mixtures, simple analgesics and antacids. Some non-prescription medicines can be sold only by pharmacists ('Pharmacist Only') or in a pharmacy ('Pharmacy Only'); others can be sold through non-pharmacy outlets such as supermarkets. Non-prescription medicines are also known as 'Over-the-Counter' (OTC) medicines.

Because of their general availability, RACF residents may select or ask their carers to select and provide these medicines. Like all medicines, CAMs and non-prescription medicines are capable of causing adverse reactions and medicine interactions.

IMPLEMENTATION GUIDE

The RACF should encourage residents and their carers to take a Quality Use of Medicines (QUM) approach² to the selection and use of CAMs and non-prescription medicines, and inform their visiting health care professionals and RACF staff when they are using or providing these medicines.

The RACF, in consultation with the MAC, should develop medication management policy and procedures for the recording and review of CAMs and self-selected non-prescription medicines used by individual residents and at facility-wide level.

The RACF medication management policy and procedures should:

- recognise that CAMs and non-prescription medicines may enter the facility by resident or carer choices;
- encourage a QUM approach to the selection and use of CAMs and non-prescription medicines;
- encourage residents and carers to inform their prescribers and staff about their use of CAMs and self-selected non-prescription medicines;
- promote recording of self selection and use of these medicines in the resident's medication chart and the resident's own medicines lists (such as a Patient Medication Profile, MediList or Medicines List);
- promote reporting to the MAC of any adverse drug events and resulting actions taken; and
- ensure the safe storage of CAMs and non-prescription medicines, and safe disposal of unwanted or expired products (see Guiding Principles 11 and 12).

Where there is extensive use of CAMs in the facility, the RACF should consider ensuring the MAC has access to a health professional with specialist expertise in these medicines to assist in the development of policy and procedures.

RESOURCES

Examples of resources relating to non-prescription medicines:

- *Non-prescription medicines (Over-The-Counter medicines)*. Therapeutic Goods Administration. www.tga.gov.au/industry/otc.htm
- Product Information and consumer medicines information (CMI).
www.ebs.tga.gov.au/ or www.nps.org.au/search_by_medicine_name

Examples of resources relating to CAMs:

- *Guiding Principles for the use of CAMs in hospitals*. Council for Australian Therapeutic Advisory Groups. www.ciap.health.nsw.gov.au/nswtag/
- *NPS Review of the Quality of Complementary Medicines Information Resources: Summary Report*. National Prescribing Service, Sydney, March 2009.
www.nps.org.au/__data/assets/pdf_file/0005/69656/CMsInfoSummary.pdf
- *Complementary Medicines*. Therapeutic Goods Administration.
www.tga.gov.au/industry/cm.htm

GUIDING PRINCIPLE 5. NURSE-INITIATED NON-PRESCRIPTION MEDICINES

The RACF should develop policies and procedures for safe practice in nurse-initiation of non-prescription medicines.

CONTEXT AND DEFINITION

Residents or their carers occasionally ask RACF staff about the relief of minor symptoms and conditions, and such requests may result in the use of commonly used non-prescription medicines. Nurses require authorisation from the RACF to select and administer non-prescription medicines in these circumstances.

Nurse-initiated non-prescription medicine involves the selection and administration of medicine/s by a registered or enrolled nurse from a list of non-prescription medicines approved by the RACF, and with the prior agreement of the resident's medical practitioner.

The use of nurse-initiated non-prescription medicine is different to:

- *nurse prescribing*, which is the legislated authority of nurse practitioners to prescribe independently;
- *PRN* medicine orders, which provide instructions for medicine administration when required in circumstances specified by the prescriber; and
- *standing orders*, which provide the authorisation to administer a specific medicine according to a protocol in specific circumstances where a prompt response is required (see Guiding Principle 6).

While the medicines authorised for nurse-initiated non-prescription medicine lists are of low risk, there is a need to assess the resident and consider the appropriateness of the medicine selected.

Nurse-initiated non-prescription medicines are only appropriate for one-off or occasional medicine use. If use of the medicine becomes routine, the resident should be reviewed by their medical practitioner and, if considered appropriate, the medicine should be prescribed on the medication chart and a resident-specific supply arranged.

IMPLEMENTATION GUIDE

The RACF should assess the need for nurse-initiated non-prescription medicines among residents and across the facility's range of care settings. Where there is such a need, the RACF should develop policy, procedures and a list of approved medicines, in consultation with the MAC, to assist nurses in safely selecting and administering these medicines.

The policy, procedures and list for the use of nurse-initiated non-prescription medicine should be reviewed regularly by the MAC and comply with relevant national, state and/or territory legislation and regulation.

The RACF policy and procedures should ensure that nurses are provided with sufficient detailed information to make informed decisions as to when and when not to select and administer a medicine from the list, including assessment, dosage, indications, and special precautions.

Nurses initiating non-prescription medicine from an approved list should:

- check that there is prior agreement from the resident's medical practitioner to use nurse-initiated non-prescription medicines;
- use professional judgement and apply a QUM approach² in selecting medicines, including consideration of non-medicine alternatives;
- consider any known allergies or previous adverse medicines events or adverse drug reactions experienced by the resident;
- select and administer the medicine in consultation with the resident and/or carer;
- record the details of the administration on the appropriate section of the resident's medication chart; and
- evaluate and document the effects of the medicine administered, including any side effects experienced.

RESOURCES

For a description of nurse-initiated medicines, see: *The National Nurse Prescribing Glossary*. National Nursing and Nursing Education Taskforce.

www.nnnet.gov.au/downloads/n3et_national_nurse_prescribing_glossary.pdf

GUIDING PRINCIPLE 6. STANDING ORDERS

The RACF should develop policies and procedures to guide the use and review of standing orders where these are used in the facility.

CONTEXT AND DEFINITION

Standing orders are sometimes used in RACFs to authorise the administration of a medicine in particular circumstances, according to a specified protocol. They are used in situations where a prompt response using a standard procedure will improve resident care and where a medicine is part of this response.

Standing orders are legal written instructions for the administration of specific medicines by an authorised person. The authorised person must have a valid and current written instruction for the specific use of the standing order.

Examples of standing orders are: an order for the administration of influenza vaccine by a registered nurse to a group of residents, or an order for a registered nurse to administer insulin to a resident with diabetes when the person's blood sugar level falls.

Use of a standing order entails clinical judgement, and the authorised person should first assess the specific circumstances for the resident involved. A standing order is NOT a 'when required' (PRN) prescription.

IMPLEMENTATION GUIDE

The RACF, in consultation with the MAC, should develop policy and procedures describing the authorisation, use and routine monitoring of standing orders where these are used in the RACF. Standing orders must be consistent with relevant state or territory legislation and regulation.

Policy and procedures for the use of standing orders should require that the order:

- is condition-specific and time-limited;
- is supported by and linked to appropriate clinical assessment;

- is clearly written, dated and signed by the prescriber;
- is regularly reviewed by the prescriber;
- specifies the medicine, dose, route and frequency;
- clearly identifies which resident/s is/are to receive the medicine, in what circumstances a particular resident is to be given the medicine, and when it is precluded;
- notes any special observations or care that may be required before or after administration of the medicine; and
- identifies by name or qualification (e.g. registered nurse) the authorised person who may administer the medicine.

Any administration of medicines according to standing orders must be recorded in the resident's medication chart.

The RACF should ensure the use of standing orders is regularly monitored and reviewed in consultation with the MAC, and that nurses authorised to use standing orders understand their roles and obligations. This should include appropriate education and training for the use of standing orders.

RESOURCES

For a description of standing orders, see: *The National Nurse Prescribing Glossary*. National Nursing and Nursing Education Taskforce.

www.nnnet.gov.au/downloads/n3et_national_nurse_prescribing_glossary.pdf

GUIDING PRINCIPLE 7. MEDICATION CHARTS

The RACF should ensure all residents have a current, accurate and reliable record of all medicines selected, prescribed and used, to support safe prescribing and administration of medicines and effective communication of medicines information between residents and their health care professionals, and between care settings.

CONTEXT AND DEFINITION

Medication charts provide a record of the prescriber's clinical intention for a resident's treatment, an order for the pharmacy supply of a resident's medicine, and a record of administration of the medicine to the resident.

Medication charts are a key tool for monitoring, review and reconciliation of a resident's medication management information. They are also an important component in the transfer of care information between RACF staff and visiting health care professionals, and between the RACF and other care settings such as community care and hospitals.

Medication charts should be an accurate, reliable and complete record of current prescribed, non-prescription and complementary or alternative medicines used by the resident.

RACFs use a range of medication chart formats, often related to service arrangements such as medicines supply systems or information transfer between the RACF and residents' health professionals and pharmacists.

The *National Residential Medication Chart* developed by the Australian Commission on Safety and Quality in Health Care is designed to provide a consistent format for medication orders and administration records, and improve the processes for pharmacist dispensing and claiming for the supply of medicines under the Pharmaceutical Benefits Scheme or Repatriation Pharmaceutical Benefits Scheme.

Interim Residential Care Medication Administration Charts are used by some hospitals to assist continuity of medication management when a resident transfers to the RACF from hospital. These charts, prepared by hospital pharmacists from

hospital discharge prescriptions, provide continuing medication orders for up to seven days until the resident's own health professional with prescribing rights (for example, a medical practitioner or nurse practitioner) reviews and prescribes ongoing treatment.

IMPLEMENTATION GUIDE

An accurate and reliable medication chart is an important information tool across the health and aged care sectors. It provides current information about medicines a person is prescribed and taking, supports continuity of care and helps to reduce medication errors.

The RACF, in consultation with the MAC, should develop policy and procedures for the use and review of medication charts, to support safety and quality in medication management. Matters to be considered include:

- taking a facility-wide integrated approach to chart selection, use and review;
- consistently using recommended terminology and abbreviations in chart entries and instructions (see Resources overleaf);
- accurately recording medication management activities such as administration and medication review;
- regularly reconciling components of each medication chart, such as:
 - prescribing, supply and administration records;
 - versions of the chart such as electronic and paper copies;
- regularly reconciling the medication chart with medication records that may be held by the resident (such as a Patient Medication Profile, MediList or Medicines List); and
- using information technologies in medication records, such as:
 - communication platforms for information exchange between the RACF, visiting health professionals and Local Health Networks;
 - emerging types of electronic medication records, such as the personally controlled electronic health record (PCEHR).

RACFs should consider working with other local health care providers to ensure consistency and compatibility in the transfer of medicines information based on medication charts, to support continuity of care across providers and settings.

Residents who self-administer their medicines should hold a current medication record such as a Patient Medication Profile, MediList or Medicines List. They should be encouraged to inform their visiting health care professionals and RACF staff of all medicines they are taking, and supported to maintain an accurate record of use.

RESOURCES

- *Interim Residential Care Medication Administration Charts*. The MedGap Project.
www.nevdgp.org.au/?content=24#MedGap
- *National Residential Medication Chart*. Australian Commission on Safety and Quality in Health Care.
www.safetyandquality.gov.au/our-work/medication-safety/medication-chart/
- *Recommendations for Terminology, Abbreviations and Symbols used in Prescribing and Administration of Medicines*. Australian Commission on Safety and Quality in Health Care.
www.safetyandquality.gov.au/wp-content/uploads/2012/01/32060v2.pdf

GUIDING PRINCIPLE 8. MEDICATION REVIEW AND MEDICATION RECONCILIATION

The RACF and residents' visiting health care professionals should ensure each resident's medication management is reviewed regularly and as needed. Medication reconciliation processes should be used to ensure residents receive all intended medicines, and to reduce risk of errors in documentation when care is transferred or new medicines are ordered.

CONTEXT AND DEFINITION

Medication review is the systematic assessment of a resident's medicines use and the management of those medicines. The focus of the review is the resident's health, independence, care and comfort. In conducting a medication review, comprehensive information about the resident's use of medicines (including self-selected medicines) is collated and assessed in order to identify and meet medicines-related needs and to identify, resolve and prevent medicines-related problems.

Regular medication review is important to make sure resident's medicines are being used safely and for best effect. It is particularly important where there has been a significant change in a resident's condition or medicines use. Regular medication review is recognised as best practice in general practitioner and pharmacist professional practice standards.

Medication review involves the resident and/or carer, the resident's medical practitioner, pharmacist, nursing staff and other relevant members of the health care team, each using their specific knowledge and expertise. The Residential Medication Management Review (RMMR) program provides funding for collaborative medication reviews in Australian Government funded RACFs for eligible residents.

Medication reconciliation is the formal process of obtaining and verifying a complete and accurate list of each resident's current medicines including prescription, non-prescription and complementary and alternative medicines (CAMs). The list is compared with the medicines ordered to identify and resolve any discrepancies with the prescriber. Any changes are documented in the resident's care records such as the medication chart. Verified information is transferred to the next care provider and the resident.

The goal of medication reconciliation is to ensure residents receive all intended medicines and to avoid errors of transcription, omission, or duplication of therapy.

Medication reconciliation processes have been shown to reduce errors and adverse events associated with poor quality information at transfer of care between facilities, care settings and providers, and reduce inaccurate documentation of medication histories on a resident's admission to hospital.

IMPLEMENTATION GUIDE

Medication Review

The RACF, in consultation with the MAC, should develop medication management policy and procedures for the use of medication reviews including regular monitoring and evaluation of their use across the facility.

The RMMR program funds collaborative medication review. The review is referred by the eligible resident's general practitioner. Accredited pharmacists are funded to conduct these reviews in RACFs under the RMMR program and there is also a Medical Benefits Schedule item available to general practitioners for referring the patient and completing a medication management plan.

The RMMR program makes medication reviews available to permanent residents of Australian Government funded RACFs. New residents should receive an RMMR as soon as possible after admission.

The RMMR program also provides examples of the circumstances that should trigger a medication review. These include:

- discharge from a hospital in the previous four weeks;
- significant changes to medication regimen in the past three months;
- change in medical conditions or abilities (including falls, cognition, physical function);
- prescription of medicines with a narrow therapeutic index or requiring therapeutic monitoring (e.g. anticoagulants, insulin);
- presentation of symptoms suggestive of an adverse drug reaction;

- sub-therapeutic response to treatment;
- suspected non-adherence or problems with managing medicine-related therapeutic devices; and
- risk of inability to continue managing own medicines (e.g. due to changes in dexterity, confusion or impaired sight).

The need for an RMMR for an existing resident can be identified by the resident's general practitioner, the pharmacist, RACF staff, the resident, the resident's carer or other members of the resident's health care team. The resident's general practitioner must assess the clinical need for an RMMR from a Quality Use of Medicines (QUM) perspective and determine that an RMMR is necessary.

The outcomes of the medication review should be reported to the resident's general practitioner and followed up by relevant health care team members according to their responsibilities, agreed strategies and monitoring of the resident's ongoing health status. The date of the current and next scheduled review should be recorded in the resident's medication chart.

Medication Reconciliation

The RACF, in consultation with the MAC, should develop medication management policy and procedures for the use of medication reconciliation processes including regular monitoring and evaluation of their use across the facility.

Health professionals with prescribing rights (for example a medical practitioner or nurse practitioner), pharmacists or registered nurses can perform medication reconciliation.

The following are examples of circumstances that should trigger medication reconciliation processes:

- admission to the RACF from the community, hospital or other care setting;
- transfer from the RACF to the community, hospital or other care setting;
- when medicines orders change or a new medicine is ordered;
- when medication charts are rewritten; and
- following a medication review.

Medication reconciliation should include all the medicines residents are taking, including any non-prescription medicines and CAMs. Medication reconciliation should also be completed for residents who self-administer their medicines.

RESOURCES

Medication Review

- *Guidelines for Residential Medication Management Review and Quality Use of Medicine services*. Pharmaceutical Society of Australia.
www.psa.org.au/download/practice-guidelines/rmmr-and-qum-services.pdf
- *MBS Primary Care Items—Medication Management Reviews*. Australian Government Department of Health & Ageing.
www.health.gov.au/internet/main/publishing.nsf/Content/medication_management_reviews.htm
- *Residential Medication Management Review*. Medicare. Australian Government Department of Human Services.
www.medicareaustralia.gov.au/provider/pbs/fifth-agreement/residential-medication-management-review.jsp
- *Residential Medication Management Review Fact Sheet*. Australian Government Department of Health & Ageing.
www.health.gov.au/internet/main/publishing.nsf/Content/rmmr-factsheet

Medication Reconciliation

- *Aged Care Home Transfer to Hospital envelope*. Australian Commission on Safety and Quality in Health Care.
www.safetyandquality.gov.au/our-work/clinical-communications/clinical-handover/national-clinical-handover-initiative-pilot-program/transfer-to-hospital-envelope/
- *Assuring Medication Accuracy at Transitions of Care: Medication Reconciliation*. Australian Commission on Safety and Quality in Health Care.
www.safetyandquality.gov.au/our-work/medication-safety/medication-reconciliation/

GUIDING PRINCIPLE 9.

CONTINUITY OF MEDICINES SUPPLY

The RACF should ensure that medicines supply is maintained for residents in changed circumstances to reduce disruption of their access to needed medicines.

CONTEXT AND DEFINITION

There are a number of circumstances where continuity of medicines supply for a resident may be interrupted. Examples include where a resident needs a new medicine or an urgent change to dose or dose form of their existing medicine after normal business hours; where a resident is transferred from hospital or another care setting with limited or no supply of medicines; or where a resident is on a short break such as respite care, leave or an outing.

Disruptions to medicine supply are reported to lead to adverse outcomes including poor symptom control and unplanned hospital admissions.

Where a dose administration aid (DAA) such as a blister pack, bubble pack or sachet is used, consideration should be given to ensuring how continuity of medicines supply will be maintained where there may be a time gap between new medicine orders and their supply in the DAA.

IMPLEMENTATION GUIDE

The RACF, in consultation with the MAC, should develop medication management policy and procedures that address how continuity of medicines supply can be addressed for different residents and circumstances, including:

- residents entering from the community for respite care;
- residents admitted from a hospital;
- residents on external outings or leave; and
- residents using DAAs whose medicines orders change or require urgent supply outside the scheduled delivery period.

Strategies to address continuity of medicines supply may include:

- providing residents and/or their carers with sufficient supplies of appropriately packaged and labelled medicines for short-term breaks such as day outings;
- providing information to residents and/or their carers about how to obtain further supply of medicines if necessary, for example on entering or leaving respite care;
- ensuring the resident has an up-to-date medicines list when on leave, such as a Patient Medication Profile, MediList or Medicines List;
- ensuring arrangements are in place with pharmacies to manage urgent supply of medicines or changes to a resident's medication order;
- ensuring arrangements are in place with pharmacies to provide after-hours or interim supply, for example where there may be delays in the DAA supply of a new or changed medicine;
- ongoing liaison with local health care services (e.g. hospitals), to address any supply barriers and ensure continuity of medicines supply for residents moving between the RACF and these services; and
- using *Interim Residential Care Medication Administration Charts* (where available in the state/territory) when residents are discharged from hospital—see Guiding Principle 7: Medication Charts.

RESOURCES

- *Guiding principles to achieve continuity in medication management* (2006). www.health.gov.au/internet/main/publishing.nsf/Content/nmp-guiding

GUIDING PRINCIPLE 10. EMERGENCY STOCK OF MEDICINES

The RACF should develop policies and procedures for the management of an emergency stock of medicines where this is used.

CONTEXT AND DEFINITION

In some jurisdictions, RACFs are permitted to hold a stock of a limited range of medicines for emergency use on the authority of a health professional with prescribing rights (for example, a medical practitioner or nurse practitioner) when normal supply arrangements are not available. Examples of emergency stock include diuretic therapy or antibiotics for acute infection.

The medicines that can be held as emergency stock and the management of this stock are subject to the legislation, regulation and policy of the relevant state/territory.

IMPLEMENTATION GUIDE

RACFs that may hold an emergency stock of medicines should have relevant policy and procedures in place. The policy and procedures should be developed in consultation with the Medication Advisory Committee (MAC), and address the following:

- any emergency stock of medicines must be in accordance with state or territory legislation and be approved for this purpose by the MAC;
- the emergency stock should include only a minimal range of medicines for emergency after-hours use;
- the MAC should determine the circumstances under which medicines held in the emergency stock may be used, who may access and administer emergency stock, and any required documentation and stock control; and
- processes should be in place for obtaining and maintaining the integrity of the stock, including appropriate storage, stock rotation, requirements for expiry date checking and processes for access, administration, recording and re-supply.

RESOURCES

Examples of state/territory requirements relating to emergency stock in RACFs:

- *Guide to the Handling of Medication in Nursing Homes in NSW. Information Bulletin 2003/10.* NSW Department of Health.
www.health.nsw.gov.au/publichealth/pharmaceutical/resources.asp
- *Key requirements for nurses in residential aged care services.* Department of Health, Victoria.
www.health.vic.gov.au/dpu/agedcare-requirements.htm

GUIDING PRINCIPLE 11. STORAGE OF MEDICINES

The RACF should ensure all medicines, including self-administered medicines, are stored safely and securely and in a manner that maintains the quality of the medicine.

CONTEXT AND DEFINITION

Medicines in a RACF should be stored securely in a way that protects the safety of all residents, staff and visitors. Storage practices should maintain the quality of each medicine, taking into account any recommended storage conditions (e.g. refrigeration) as outlined in the medicine Product Information. Storage of all medicines, including self-administered non-prescription and complementary and alternative medicines, must be consistent with relevant state or territory legislation and regulation.

IMPLEMENTATION GUIDE

The RACF, in consultation with the MAC, should develop medication management policy and procedures on the storage of all medicines, including those managed and self-administered by residents. In addition to maintaining the quality of the medicine, facilities should consider safety and security issues such as prevention of unauthorised access.

Medicine storage policy and procedures should be consistent with the requirements of relevant state or territory legislation and regulation. Pharmacists can advise on safe and appropriate storage conditions for all medicines.

All medicines should be stored in accordance with instructions on the manufacturer's label or dose administration aid (DAA) label. Generally, medicines should be stored in a cool, dry and secure place, however there are some special storage issues that must be considered:

- **Refrigeration.** The stability and effectiveness of some medicines depends on storing them at the correct temperature (e.g. some vaccines and insulin require refrigeration). Refrigeration of medicines should be separate to food storage;

- **Storage in DAAs.** Some medicines with particular storage, stability or schedule requirements are not suitable for use in DAAs or may need to be packaged in a specific manner. For example, PRN medicines should be packed separately; cytotoxic medicines should be packed separately with appropriate cautionary labels; and Schedule 8 medicines should be packed according to state or territory legislative and regulatory requirements;
- **Cytotoxic medicines.** Storage of cytotoxic medicines and cytotoxic waste must comply with the requirements of state or territory legislation. The RACF should develop a specific policy in consultation with the MAC on the storage of cytotoxic products;
- **Storage facilities (including lockable cabinets, medicines trolleys and medicines storage areas).** Consideration should be given to the design, location and use of medicines storage facilities including those for residents who are self-administering; storage of medicine-related equipment, such as syringes and needles; and safety and security issues such as preventing unauthorised access; and
- **Stock control and rotation.** All medicines have an expiry date and this should be checked along with storage requirements. The RACF should ensure staff involved in medication management are familiar with and comply with the storage requirements for medicines used in the facility.

RESOURCES

- *National vaccine storage guidelines—Strive for 5.* Immunise Australia Program. Australian Government Department of Health and Ageing. www.health.gov.au/internet/immunise/publishing.nsf/content/provider-store
- *Product Information* (which provides details of each medicine's storage requirements). Therapeutic Goods Administration. www.ebs.tga.gov.au/

GUIDING PRINCIPLE 12.

DISPOSAL OF MEDICINES

The RACF should ensure that unwanted, ceased or expired medicines are disposed of safely to avoid accidental poisoning, misuse and toxic release into the environment.

CONTEXT AND DEFINITION

Medicines that are unwanted, have been ceased or have expired should be disposed of in a way that is safe and reflects contemporary best practice. Medicines disposal should not result in accidental poisoning, accidental or intentional misuse or contamination of the environment.

The Return Unwanted Medicines (RUM) Project is funded by the Australian Government to ensure that unwanted medicines are disposed of in accordance with regulatory and state or territory environment protection authority requirements. RUM uses the national community pharmacy network to collect expired and unwanted medicines.

IMPLEMENTATION GUIDE

The RACF, in consultation with the MAC, should develop medication management policy and procedures on the disposal of all medicines. Policy and procedures should be consistent with relevant state or territory legislation, regulation and directives (e.g. those governing the disposal of Schedule 8 medicines, cytotoxic medicines and cytotoxic waste). Pharmacists can advise on specific medicine disposal requirements.

In developing policy and procedures, the RACF should consider:

- disposal methods that avoid any risk of accidental poisoning, intentional or accidental misuse or environmental harm, with particular attention to the additional risks to work health and safety posed by vaccines, cytotoxics, opioids, and equipment such as syringes and needles;

- management of privacy issues in the disposal of unwanted medicines, such as information on medicine labels that identifies residents; and
- medicines disposal by residents who are self-administering.

Medicines return and disposal practices may also provide quality assurance feedback. For example, monitoring of returned, unused medicines in dose administration aids (DAAs) may assist in gauging adherence to treatment plans.

RESOURCES

- Return Unwanted Medicines (RUM) Project.
www.returnmed.com.au/ or phone 1300 650 835

GUIDING PRINCIPLE 13.

SELF-ADMINISTRATION OF MEDICINES

The RACF should support those residents who wish to administer their own medicines as part of maintaining their independence. This should follow assessment and regular review of these residents' capacity to self-administer medicines safely.

CONTEXT AND DEFINITION

The *Quality of Care Principles 1997* recognise that residents retain their personal, civic, legal and consumer rights, and promote assisting residents to achieve active control of their own lives within the residential aged care service.

Where residents have been formally assessed as being able to self-administer their medicines, including prescription, non-prescription and complementary and alternative medicines (CAMs), they should be supported to do so. This responsibility can be important for the resident in maintaining a level of independence and increasing knowledge about his or her medicines.

The person's capacity and willingness to self-administer their medicines should be re-assessed regularly, and especially when there is a change in health or cognitive status.

IMPLEMENTATION GUIDE

The RACF, in consultation with the MAC, should develop medication management policy and procedures on resident self-administration of medicines.

A health professional regulated by the *Health Practitioner Regulation National Law Act 2009*, such as a medical practitioner, pharmacist or registered nurse should assess residents who wish to self-administer their medicines. Some residents may wish to self-administer only some of their medicines, such as the oral dose forms, but have other dose forms such as injections administered by a nurse.

Assessment should cover:

- cognitive capacity, including understanding of the safe and quality use of the medicines taken;
- physical ability, including dexterity, visual acuity and swallowing; and
- how information such as Consumer Medicine Information (CMI) and practical support such as a dose administration aid (DAA) may assist the resident to self-administer their medicine/s.

The assessment should be repeated at regular intervals and as required; for example, if there is a change in the resident's physical or cognitive status. The resident's medication chart should record that he or she has been assessed for self-administration and is self-administering all or part of their medicine/s.

Residents who self-administer their medicines should hold a current record of their medicines such as a Patient Medication Profile, MediList or Medicines List. They should be encouraged to inform their visiting health care professionals and RACF staff of all medicines they are taking and supported to maintain an accurate record of self-administration.

The storage and disposal of self-administered medicines should be consistent with RACF policy and procedures (see Guiding Principle 11: Storage of Medicines and Guiding Principle 12: Disposal of Medicines).

RESOURCES

CMI is available for all prescription and pharmacist-only medicines. These may be included in the medicine package, but can also be requested from the RACF, pharmacist or doctor. They are also available from:

- www.ebs.tga.gov.au/—an index of CMI searchable by medicine, trade name or active ingredient
- www.nps.org.au/search_by_medicine_name: an index of CMI searchable by medicine name

Examples of information for consumers about managing medicines:

- *Fact Sheets on managing medicines.* Consumers Health Forum.
www.chf.org.au/fact-sheets.php
- *Medicines Talk.* NPS: Better Choices Better Health
www.nps.org.au/consumers/publications/medicines_talk
- *Tips about the wise use of medicines.* NPS Better Choices Better Health.
www.nps.org.au/consumers/tools_and_tips/medicines_tips

Examples of Medicines Lists:

- *Medicines List.* NPS: Better Choices Better Health.
www.nps.org.au/consumers/tools_and_tips/medicines_list
- *MediList.* Australian Government Department of Veterans Affairs.
www.dva.gov.au/health_and_wellbeing/self-management/Pages/MediList.aspx
- The NPS *Medicines List* is also available as a free iPhone, iPad or iPod Touch app that can provide reminders and alerts for medicines and when these should be taken. This app is available from the iTunes App Store.
<http://search.itunes.apple.com/WebObjects/MZContentLink.woa/wa/link?path=apps%2fmedicineslist>

GUIDING PRINCIPLE 14.

ADMINISTRATION OF MEDICINES BY RACF STAFF

The RACF should ensure that staff are appropriately qualified and authorised to administer medicines, and that administration practices are monitored for safety and quality.

CONTEXT AND DEFINITION

National, state and territory legislation and regulation, and relevant professional standards govern medicines administration roles, responsibilities and practice by a number of health professionals in RACFs. Nursing staff are most commonly responsible for the administration of medicines in RACFs.

Registered nurses are qualified and legally authorised to administer medicines under the *Health Practitioner Regulation National Law Act 2009*, and relevant state and territory legislation and regulation.

Enrolled nurses work under the direction and supervision of registered nurses. Under the *Health Practitioner Regulation National Law Act 2009*, all enrolled nurses may administer medicines except for those who have a notation on the register against their name that reads '*Does not hold Board-approved qualification in administration of medicines*'.

Registered and enrolled nurses are professionally regulated through the Nurses and Midwives Board of Australia and are accountable to professional standards.

In some jurisdictions, assistants in nursing/personal care workers (however titled) perform medicines-related tasks in accordance with state or territory legislation and regulation and RACF policy and procedures. These staff are not professionally licensed, so are not bound by standards set by a licensing authority.

IMPLEMENTATION GUIDE

The primary focus of medicines administration practice is on ensuring quality outcomes for residents through the safe and correct administration of medicines. This includes ensuring that the right medicine is administered to the right person in the right dose at the right time via the right route.

Monitoring the outcomes of medicines administered to residents, and having effective processes for recording medicines-related problems are especially important given the correlations between age, use of multiple medicines, adverse drug events, medication errors and medication incidents.

The RACF, in consultation with the MAC, should develop medication management policies and procedures to ensure safe, quality medicines administration practices. Policy and procedures should be consistent with:

- national, state or territory legislation and regulation;
- professional practice guidelines;
- the qualifications, authorisation and competencies of staff administering medicines; and
- evidence-based best practice (e.g. clinical or therapeutic guidelines).

RACF policy and procedures for medicines administration should address:

- identification of the resident;
- checking for allergies and adverse drug reactions;
- medicines checking and reconciliation processes;
- recording of medicines administration;
- monitoring and recording effects of medicines;
- reporting medicine-related errors, incidents and adverse drug events;
- special requirements for administering 'high risk' medicines such as those with a narrow therapeutic index or at risk of misuse or abuse; and
- appropriate administration practices, for example use of oral and injectable forms, ointments, drops, inhalers, and nebulisers.

The RACF policy and procedures should specify the circumstances under which registered nurses can delegate medicine administration tasks to appropriately trained and competent staff, where this is permitted by relevant state or territory legislation and regulation. Where medicine administration tasks are delegated to staff by registered nurses, the delegated staff should have formal training in medicine administration, be assessed by the RACF and the registered nurse as competent to administer medicines, accept the delegation, and be appropriately supervised.

The RACF should use ongoing quality improvement activities such as staff education and training and ongoing competency assessment, developed in consultation with the MAC, to support appropriate medicines administration, monitoring and reporting practices.

RESOURCES

- *Explanatory note: Enrolled Nurses and Medication Administration.* The Nursing and Midwifery Board of Australia.
www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ.aspx
- *Guidelines on Delegation and Supervision for Nurses and Midwives (2007).* Australian Nursing and Midwifery Council.
www.anmc.org.au/positon_statements_and_guidelines
- *Nursing Guidelines for Medication Management in Aged Care (2012).* Australian Nursing Federation and Royal College of Nursing Australia.
http://www.anf.org.au/html/publications_reports.html
- *Professional Codes, Guidelines and Statements for Nurse Practitioners, Registered Nurses and Enrolled Nurses.* The Nursing and Midwifery Board of Australia.
www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx#competencystandards

GUIDING PRINCIPLE 15. DOSE ADMINISTRATION AIDS

The RACF should develop policies and procedures to guide dose administration aid needs assessment, preparation, use, monitoring and quality assurance.

CONTEXT AND DEFINITION

Dose administration aids (DAAs) are devices or packaging systems such as blister packs, bubble packs or sachets for organising doses of medicines according to the time of administration. A DAA can be either a unit-dose pack (one single type of medicine contained within each blister or sachet) or a multi-dose pack (different types of medicines contained within each blister or sachet).

DAAs are designed to assist medication management for a resident by having medicines divided into individual doses and arranged according to the dose schedule throughout the day.

Whilst the use of DAAs in RACFs is widespread, it should be noted that guidance on the stability of medicines re-packaged in DAA systems is very limited. From the perspective of the pharmaceutical manufacturer, the removal of any medicine from the environment in which it has undergone stability testing, to one where it has not, reduces or invalidates the shelf life indicated on the label. The pharmacist will need to make a risk assessment on the basis of individual medicines and individual consumers.²⁶

Medicines in DAAs may include prescription, non-prescription and complementary and alternative medicines (CAMs), but only solid oral medicines can be packaged in this way. In addition, some medicines with particular storage, stability or schedule requirements are not suitable for use in DAAs or may need to be packaged in a specific manner. For example, PRN medicines should be packed separately; cytotoxic medicines should be packed separately with appropriate cautionary labels; and Schedule 8 medicines should be packed according to national, state or territory legislative requirements.

Community pharmacists usually prepare DAAs. This is done in accordance with professional guidelines and standards and relevant state or territory legislation. In some states and territories, in exceptional circumstances and where a pharmacist is not available, a health professional such as a medical practitioner, registered nurse or Aboriginal Health Worker may be authorised to prepare a DAA.

Where DAAs are used, they should be prepared, labelled, distributed, stored and used according to relevant legislation and regulation, and professional guidelines and standards.

DAAs offer a number of benefits, but they are not an infallible system. Benefits include their convenience and support for medication management, particularly in providing an audit trail for medicines dispensed and administered. Potential problems include:

- errors in packing and delivery;
- inflexibility of ordering and supply systems when medicine orders change;
- interruptions to the continuity of medicines supply, for example when a resident moves across care settings; and
- the cost to residents and the facility, which can be a barrier to some residents.

IMPLEMENTATION GUIDE

The RACF, in consultation with the Medication Advisory Committee (MAC), should develop policy and procedures that address the supply, use and monitoring of DAAs. The following areas should be addressed:

Assessment of resident need and ability to use a DAA safely and effectively

Where medication management for a resident may be assisted by the use of a DAA, the need for this should be assessed systematically and routinely. Residents who self-administer their medicines should also be formally assessed for their suitability and capacity to use a DAA safely and effectively, and whether they require additional help or information in using a DAA.

Some residents may be limited by physical factors such as arthritis or vision impairment; literacy barriers in reading and interpreting label instructions; or difficulty in managing a complex medicines regimen. Some categories of resident may not be suitable for DAA supply, for example temporary residents who have an existing community supplier of medicines.

Assessment of a resident's suitability for a DAA should also take into account the person's rights, such as choice of pharmacy service, and any costs associated with obtaining his or her medicines in DAAs. Regular medication reviews should reassess the continuing requirement for use of DAAs by the resident.

Medicines information for residents

DAA policy and procedures should consider how to meet the information needs of residents and their carers about medicines provided in DAAs; for example, through providing a list of current medicines such as a Patient Medication Profile, MediList or Medicines List; and providing Consumer Medicines Information (CMI).

DAA ordering processes

Timely and accurate communication is needed between health professionals with prescribing rights (for example, a medical practitioner or nurse practitioner), pharmacists and RACF staff about medicines ordered in DAAs, as the time between ordering, preparation and delivery can affect continuity of medicines supply. Matters to be considered include:

- whether unit dose or multi-dose packs are appropriate;
- how to communicate to the supply pharmacist medicine orders or changes, including whether these require 'immediate' or 'next-pack' changes; and
- how continuity of access to medicines supply will be maintained when medicine orders change (see Guiding Principle 9: Continuity of Medicines Supply).

Monitoring and reporting for utilisation and quality performance

The use of DAAs in the RACF should be monitored and regularly reviewed for errors in labelling, packing and administration. Monitoring should also include regular reconciliation of the DAA and the medication chart.

DAA systems performance should be regularly monitored, reviewed and reported to the MAC as part of continuing quality improvement activities in medication management. This should include systematic reporting of packing or labelling errors.

Suitability of medicines for packaging in DAA

RACF policy and procedures on DAAs should address how residents' medication management needs will be met where:

- medicines need to be packed across multiple DAAs (e.g. in short course treatment);
- there are irregular dosing schedules (e.g. alternate days or weekly); and
- there are medicines that cannot be packed with other medicines in a DAA (e.g. cytotoxics, or 'as required' [PRN] medicines).

Labelling of DAAs

Labelling of DAAs should comply with relevant professional practice standards, such as those of the Pharmaceutical Society of Australia. Labelling considerations include:

- accurate identification of the resident;
- identification of individual medicines, strength and form;
- date and day of week each medicine is to be administered;
- any specific instructions for the use of the medicine/s, including directions for the use of each medicine and cautionary and advisory labels, and any information about alteration of dose form;
- indication where other medicines for the resident (e.g. cytotoxic medicines, anticoagulants, inhalers) are contained in additional DAA pack/s or containers for administration as applicable;

- information on storage time of the medicine;
- details of the person/service packing the medicines in the DAA;
- dates of packing, commencement and expiry of the DAA; and
- any other details according to legislative and regulatory labelling requirements.

Provisions for disposal or return of unwanted/unused DAAs

Policy and procedures should address:

- how unwanted, ceased or expired medicines in DAAs will be identified and returned to the pharmacy for disposal (see Guiding Principle 12: Disposal of Medicines); and
- how DAAs are returned to the pharmacy for resupply where a medicine order changes.

Administration of medicines from DAAs

Medicines packed in DAAs may be self-administered by a resident who has been assessed as being able to do so, either with or without assistance, or be administered by a registered or enrolled nurse. Assistants in nursing/personal care workers (however titled) may be authorised and delegated to assist in administration of medicines from a DAA, where permitted by state or territory legislation and regulation, and RACF policy and procedures.

RACF policy and procedures should address administration of medicines from DAAs for all residents and staff who use these tools, and should be consistent with Guiding Principle 13: Self-administration of Medicines; and Guiding Principle 14: Administration of Medicines by RACF staff.

RACF policy and procedures should also cover the following:

- ensuring packaging integrity: DAAs use tamper-evident packaging features that show if the container has been accessed before the medicine has been administered. Medicine from any DAA that has been tampered with should not be administered, the incident should be reported to the MAC, and the DAA should be returned to the supply pharmacy;

- monitoring for deterioration of medicines: RACF staff, and residents self-administering medicines from a DAA should also monitor packs for any changes such as changes in colour or disintegration of the medicine. If any deterioration is detected, the medicine should not be administered, the incident should be reported to the MAC as a medication incident and the DAA should be returned to the supply pharmacy;
- preventing cross-contamination of medicines where oral dose forms are altered using crushing tools that are not adequately cleaned between uses (see Guiding Principle 16: Alteration of Oral Dose Forms); and
- reducing risks to infection control: There may be a risk to infection control from the re-use of soiled non-disposable components of DAA packs (e.g. plastic covers).

Education and training

The RACF should have policy and procedures for staff and resident education and training required to support the safe and effective use of DAAs.

RESOURCES

- *Dose Administration Aids service*: Pharmaceutical Society of Australia.
www.psa.org.au/supporting-practice/professional-practice-standards/dose-administration-aids-service
- *Guidelines on specialised supply arrangements*. Pharmacy Board of Australia.
www.pharmacyboard.gov.au/Codes-Guidelines.aspx

GUIDING PRINCIPLE 16.

ALTERATION OF ORAL DOSE FORMS

The RACF should ensure that residents, their carers and staff administering medicines know which oral dose medicines can and cannot be altered in form, such as by crushing or chewing and any special conditions relating to the alteration or administration of specific medicines.

CONTEXT AND DEFINITION

Wherever possible, oral dose forms of medicines should not be altered. Some medicines must not be altered at all and if administration is an issue, an alternative medicine or different forms of the medicine should be considered. Alternative forms that may be available include dispersible tablets, liquids, topical applications, patches, intranasal sprays, suppositories, injections or stable extemporaneous mixtures.

Where the form of a medicine is altered to assist administration, such as by crushing, care must be taken that the alteration does not result in reduced effectiveness, a greater risk of toxicity or other harm, an unacceptable presentation to the resident in terms of taste or texture, or a risk to work health and safety. It is important to ensure the crushed medicine can be easily swallowed and that adequate fluid is given with altered dose forms to aid ingestion.

Cross-contamination of one resident's medicine with that of another can occur where the same crushing tool is used for more than one resident without proper cleaning between residents. This can have serious consequences (for example if a resident is allergic to a medicine such as penicillin).

IMPLEMENTATION GUIDE

Registered and enrolled nurses administering medicines, residents who are self-administering medicines, and others assisting residents in medicines administration, such as assistants in nursing/personal care workers (however titled) or family carers, should be informed and aware of the risks associated with altering the oral dose form of a medicine. This includes being aware of instructions on medicines packaging and dose administration aids (DAAs) and in Consumer Medicines Information (CMI) that indicate if the form is not to be altered (e.g. 'do not crush or chew').

Wherever possible, oral dose forms of medicines should not be altered. Before deciding to alter a dose form, consideration should be given to:

- the reason the resident is unable to swallow the medicine in its usual form, and any therapy that may assist;
- whether the resident is ordered any medicines that should not be modified;
- whether the medicine is still indicated;
- if there are alternative forms available; and
- if there are alternative medicines available.

The RACF, in consultation with the MAC, should develop a list of medicines that must not be altered in dose form. This list should be in a readily accessible location, and updated regularly and whenever a new product that requires specific instructions becomes available. The supplying pharmacist should provide relevant and timely information on new products to the RACF and MAC.

The RACF, in consultation with the MAC, should also develop policy and procedures that address alteration of oral dose forms of medicines. The procedures should cover medicines provided both in original packaging and those provided in DAAs, and should address:

- the requirement to adhere to the 'do not alter' instruction for the list of medicines so designated;
- awareness of the potential risks and effects on safety and efficacy of a medicine when the oral form is altered;
- the appropriateness of the medium (e.g. food or liquid), if any, in which the crushed medicine is dispersed and any impact of that medium on the medicine's efficacy;
- appropriate ways to administer crushed medicines, such as using an appropriate type and amount of fluid to help the person swallow the medicine, and ensuring the total prescribed dose is administered;
- the acceptability of the altered presentation to the resident; and
- risks of medicines contamination and infection control in the use of crushing and administration tools.

RACF staff should receive education and training on the alteration of oral dose forms of medicines. This can be part of QUM services provided by the RACF's pharmacist.

RESOURCES

- Medicines labels, Product Information and CMI indicate if the medicine form should not be altered. Product Information and CMI is available from a searchable database at the Therapeutic Goods Administration: **www.ebs.tga.gov.au**
- There are a number of detailed guides on the alteration of oral dose forms available for purchase; for example:
 - *AMH Drug Choice Companion: Aged Care*. Australian Medicines Handbook. **www.amh.net.au**
 - *Australian Don't Rush to Crush Handbook*. The Society of Hospital Pharmacists of Australia. **www.shpa.org.au/scripts/cgiip.exe/WService=SHPA/ccms.r?Pageid=10243**
 - *Australian Pharmaceutical Formulary and Handbook*. The Pharmaceutical Society of Australia. **www.psa.org.au/shop/apf**

GUIDING PRINCIPLE 17.

EVALUATION OF MEDICATION MANAGEMENT

The RACF should regularly review and evaluate each area of medication management for outcomes and take follow-up action where required.

CONTEXT AND DEFINITION

Evaluation of all aspects of medication management is essential to identify quality use of medicines (QUM) outcomes, resolve problems and improve service quality.

Evaluation can occur at individual, group and facility-wide level, for example addressing:

- an individual resident's medication management, through medication review or assessment for self-administration;
- a group of residents receiving the same types of medicines (e.g. psychotropics, medicines for pain or bowel management), through review against clinical and therapeutic guidelines and in drug use evaluation (DUE) activities;
- management of different classes of medicines used within the facility (e.g. high risk medicines), through the review of supply, handling, administration and disposal practices;
- medicines-related outcomes or problems (e.g. adverse drug reactions, medication errors), through adverse drug reaction and error surveillance and reporting;
- medicines-related services, such as monitoring dose administration aids (DAAs) for packing errors, or staff education and training activities in medication management;
- medicines-related processes such as administration practices and alteration of oral dose forms, through audits or competency assessments; and
- medicines-related infrastructure and resources, such as use of the Medication Advisory Committee (MAC) or information technology resources.

IMPLEMENTATION GUIDE

The RACF should establish an environment that fosters continuing quality improvement in medication management. The aim is to meet the medicines-related needs of all residents and support continuity of medication management across different care settings within the RACF, and in transfers to other care settings such as hospitals and the community.

The RACF, in consultation with the MAC, should develop policy and procedures for the systematic evaluation of medication management. Evaluation processes should include routine, scheduled evaluation activities; incident and error reporting; follow-up actions such as process redesign or education and training; and review of the effectiveness of those follow-up actions.

Evaluation of medication management should be a designated component of the risk management and continuing quality assurance activities of the RACF. Evaluation should also consider how medication management relates to other service functions such as pharmacy services, purchasing and supply arrangements, facility records management and information technology systems.

The following checklist provides examples of questions to evaluate the application of these Guiding Principles in the RACF. Facilities are encouraged to formulate additional locally-relevant questions to help measure, report, review and develop the safety and quality of their medication management.

CHECKLIST OF THE GUIDING PRINCIPLES AND EVALUATION QUESTIONS

Guiding principle

Examples of evaluation questions

GUIDING PRINCIPLE 1.

MEDICATION ADVISORY COMMITTEE

The RACF should establish (or have direct access to) and use a Medication Advisory Committee to support the safe and effective management and quality use of medicines in the facility.

Does the RACF use a multi-disciplinary MAC that meets regularly?

Does the MAC advise the RACF on developing policy and procedures for medication management?

Does the MAC regularly monitor, review and evaluate safe and quality use of medicines in the RACF?

Does the MAC have a mechanism to address medicines-related issues with the RACF management and Board?

GUIDING PRINCIPLE 2.

INFORMATION RESOURCES

The RACF should ensure that current and accurate medicines information resources are available to all residents, carers, staff and visiting health care professionals.

Does the RACF have current and accurate medicines information resources available, developed in consultation with the MAC?

Are information resources readily available to all staff, visiting health care practitioners, residents and carers to support their roles in safe, quality medicines use in the RACF?

Are information resources used to support and promote continuing quality assurance in medication management?

GUIDING PRINCIPLE 3.

SELECTION OF MEDICINES

The RACF should support informed and considered selection of all medicines used in the facility.

Does the RACF support a QUM approach to the selection of all medicines used in the facility?

Are policies, procedures and information resources readily available to assist RACF staff, visiting health care practitioners, residents and carers in informed and considered selection of medicines?

Is medicines use in the facility regularly reviewed and evaluated for safety and quality improvement?

CHECKLIST OF THE GUIDING PRINCIPLES AND EVALUATION QUESTIONS

Guiding principle

Examples of evaluation questions

GUIDING PRINCIPLE 4.

COMPLEMENTARY, ALTERNATIVE AND SELF-SELECTED NON-PRESCRIPTION MEDICINES

The RACF should support informed selection and safe use of complementary, alternative and self-selected non-prescription medicines used by residents.

Does the RACF have policy and procedures for the management of complementary, alternative and self-selected non-prescription medicines used in the facility, developed in consultation with the MAC and consistent with the requirements of relevant state or territory legislation and regulation?

Are residents and carers encouraged to inform RACF staff and visiting health care professionals about the resident's use of self-selected medicines?

Is use of self-selected medicines recorded in the resident's medication chart and resident-held medicines list?

Are self-selected medicines stored safely within the RACF?

Are adverse events from self-selected medicines recorded by the RACF and reported to the MAC?

GUIDING PRINCIPLE 5.

NURSE-INITIATED NON-PRESCRIPTION MEDICINES

The RACF should develop policies and procedures for safe practice in nurse-initiation of non-prescription medicines.

Does the RACF have policy and procedures for safe practice in nurse-initiation of non-prescription medicines, developed in consultation with the MAC, consistent with the requirements of relevant state or territory legislation and regulation?

Is there a written list of nurse-initiated non-prescription medicines, approved by the MAC?

Does the MAC regularly review the list?

Are the administration and outcomes of nurse-initiated medicines recorded and reviewed?

CHECKLIST OF THE GUIDING PRINCIPLES AND EVALUATION QUESTIONS

Guiding principle

Examples of evaluation questions

GUIDING PRINCIPLE 6. STANDING ORDERS

The RACF should develop policies and procedures to guide the use and review of standing orders where these are used in the facility.

Does the RACF have policy and procedures for standing orders where these are used, developed in consultation with the MAC, consistent with the requirements of relevant state or territory legislation and regulation?

Is there regular and recorded review of all standing orders and their use?

GUIDING PRINCIPLE 7. MEDICATION CHARTS

The RACF should ensure all residents have a current, accurate and reliable record of all medicines selected, prescribed and used, to support safe prescribing and administration of medicines and effective communication of medicines information between residents and their health care professionals, and between care settings.

Does the RACF have policy and procedures on the use of medication charts and related medication records, developed in consultation with the MAC?

Is there regular review of medication records for currency and accuracy?

GUIDING PRINCIPLE 8. MEDICATION REVIEW AND MEDICATION RECONCILIATION

The RACF and residents' visiting health care professionals should ensure each resident's medication management is reviewed regularly and as needed. Medication reconciliation processes should be used to ensure residents receive all intended medicines, and to reduce risk of errors in documentation when care is transferred or new medicines are ordered.

Does the RACF have policy and procedures addressing medication review and reconciliation, developed in consultation with the MAC?

Are residents' medicines reviewed regularly and as required and follow-up action taken where necessary?

Is medication reconciliation performed regularly and as required?

Does the MAC monitor the use of medication review and reconciliation processes at facility level?

CHECKLIST OF THE GUIDING PRINCIPLES AND EVALUATION QUESTIONS

Guiding principle

Examples of evaluation questions

GUIDING PRINCIPLE 9.

CONTINUITY OF MEDICINES SUPPLY

The RACF should ensure that medicines supply is maintained for residents in changed circumstances to reduce disruption of their access to needed medicines.

Does the RACF have policy and procedures to address and support continuity of medicines supply for all residents, developed in consultation with the MAC?

GUIDING PRINCIPLE 10.

EMERGENCY STOCK OF MEDICINES

The RACF should develop policies and procedures for the management of an emergency stock of medicines where this is used.

Does the RACF have policy and procedures for the emergency stock of medicines approved for this purpose, developed in consultation with the MAC?

Are the policy and procedures consistent with the requirements of relevant state or territory legislation and regulation?

Do the policy and procedures address the use of emergency stock, recording and stock control?

GUIDING PRINCIPLE 11.

STORAGE OF MEDICINES

The RACF should ensure all medicines, including self-administered medicines, are stored safely and securely and in a manner that maintains the quality of the medicine.

Does the RACF have policy and procedures on the safe storage of all medicines used in the RACF, developed in consultation with the MAC, consistent with the requirements of relevant state or territory legislation and regulation?

Are residents who self-administer their medicines informed of policy and procedures for the safe storage of their medicines?

CHECKLIST OF THE GUIDING PRINCIPLES AND EVALUATION QUESTIONS

Guiding principle

Examples of evaluation questions

GUIDING PRINCIPLE 12.

DISPOSAL OF MEDICINES

The RACF should ensure that unwanted, ceased or expired medicines are disposed of safely to avoid accidental poisoning, misuse and toxic release into the environment.

Does the RACF have policy and procedures that address the safe disposal of all unwanted, ceased or expired medicines and medicines-related waste, developed in consultation with the MAC, consistent with the requirements of relevant state or territory legislation and regulation?

Are residents who self-administer their medicines informed of policy and procedures for the safe disposal of their medicines?

GUIDING PRINCIPLE 13.

SELF-ADMINISTRATION OF MEDICINES

The RACF should support those residents who wish to administer their own medicines as part of maintaining their independence. This should follow assessment and regular review of the residents' capacity to safely self-administer medicines.

Does the RACF have policy and procedures for assessment, support, recording and review of resident self-administration of medicines, developed in consultation with the MAC?

Are residents adequately supported to administer their own medicines, assisted as appropriate to have a current medicines list such as a Patient Medication Profile, MediList or Medicines List?

In practice, is the storage and disposal of self-administered medicines consistent with RACF policies and procedures?

CHECKLIST OF THE GUIDING PRINCIPLES AND EVALUATION QUESTIONS

Guiding principle

Examples of evaluation questions

GUIDING PRINCIPLE 14.

ADMINISTRATION OF MEDICINES BY RACF STAFF

The RACF should ensure that staff are appropriately qualified and authorised to administer medicines, and that administration practices are monitored for safety and quality.

Does the RACF have policy and procedures on medicines administration by staff, developed in consultation with the MAC, consistent with the requirements of relevant national, state or territory legislation and regulation?

Are RACF staff trained, assessed and authorised to perform medicine administration roles?

Is all medicine administration by staff documented?

Are there processes for recording and reporting medicine administration outcomes, including adverse drug events?

GUIDING PRINCIPLE 15.

DOSE ADMINISTRATION AIDS

The RACF should develop policies and procedures to guide dose administration aid needs assessment, preparation, use, monitoring and quality assurance.

Does the RACF have policy and procedures that address the supply, use, monitoring, storage and disposal of DAAs developed in consultation with the MAC?

Are residents regularly assessed for their suitability and capacity to use a DAA?

Are residents and carer information needs about DAA use, storage and disposal addressed?

Is DAA systems performance regularly monitored, reviewed and reported to the MAC?

Are staff, residents and carers informed and educated on the safe and effective administration of medicines from DAAs?

CHECKLIST OF THE GUIDING PRINCIPLES AND EVALUATION QUESTIONS

Guiding principle

Examples of evaluation questions

GUIDING PRINCIPLE 16.

ALTERATION OF ORAL DOSE FORMS

The RACF should ensure that residents, their carers and staff administering medicines know which oral dose medicines can and cannot be altered in form, such as by crushing or chewing and any special conditions relating to the alteration or administration of specific medicines.

Does the RACF have policy and procedures on the alteration of dose forms of oral medicines, developed in consultation with MAC?

Does the RACF have a regularly reviewed list of medicines that must not be crushed or altered, developed in consultation with the MAC?

Is the list readily accessible to people administering medicines?

Is information on alteration of oral dose forms provided to residents who are self-administering?

GUIDING PRINCIPLE 17.

EVALUATION OF MEDICATION MANAGEMENT

The RACF should regularly review and evaluate each area of medication management for outcomes and implement follow-up action where required.

Does the RACF have policy and procedures for the systematic evaluation of each area of medication management in the RACF, developed in consultation with the MAC?

Is a systematic review of each area of medication management in the RACF conducted regularly?

Are follow-up actions for safety and quality improvement implemented and reviewed by the MAC?

STATE AND TERRITORY CONTACTS FOR REGULATORY/POLICY ADVICE

NEW SOUTH WALES

Pharmaceutical Services
New South Wales Department of Health

General Queries

Telephone: (02) 9879 3214

Fax: (02) 9859 5165

Email: pharmserv@doh.health.nsw.gov.au

Web: www.health.nsw.gov.au/PublicHealth/Pharmaceutical/contacts.asp

QUEENSLAND

Environmental Health Branch
PO Box 2368, Fortitude Valley BC, Qld 4006

Telephone: (07) 3328 9310

Facsimile: (07) 3328 9354

Email: ehu@health.qld.gov.au

Medicines Policy Issues:

Medication Services Queensland
GPO Box 48, Brisbane, Qld 4001

Telephone: (07) 3131 6500

Fax: (07) 3131 6683

Legislation Issues:

Legislative Policy Unit
GPO Box 48, Brisbane, Qld 4001

Telephone: (07) 3234 0289

Email: legislation@health.qld.gov.au

Web: www.health.qld.gov.au/legislation/default.asp

Information about medicines and poisons, as it applies to health practitioners, industry and the public in Queensland can be found on: www.health.qld.gov.au/health_professionals/medicines/

VICTORIA

Department of Health
Drugs and Poisons Regulation Group
GPO Box 4541, Melbourne, Vic 3001

Telephone: 1300 364 545 or (03) 9096 1067

Fax: 1300 360 830

Web: www.health.vic.gov.au/dpu

SOUTH AUSTRALIA

Drug & Alcohol Services South Australia
PO Box 6, Rundle Mall, Adelaide, South Australia 5063

Telephone: (08) 8274 3333

Fax: (08) 8274 3399

Email: dassa.pharmservices@health.sa.gov.au

WESTERN AUSTRALIA

The Pharmaceutical Services Branch
PO Box 8172, Perth Business Centre, WA 6849

Telephone: (08) 9222 6883

Fax: (08) 9222 2463

Email: poisons@health.wa.gov.au

Web: www.public.health.wa.gov.au/1/872/2/pharmaceutical_services.pm

TASMANIA

Pharmaceutical Services
Department of Health and Human Services

Telephone: (03) 6233 2064
Fax: (03) 6233 3904
Web: www.dhhs.tas.gov.au/psbtas

AUSTRALIAN CAPITAL TERRITORY

Pharmaceutical Services
ACT Health
Howard Florey Centenary House
25 Mulley Street, Holder, ACT 2611

Telephone: (02) 6205 0996
Fax: (02) 6205 0997

NORTHERN TERRITORY

Poisons Control
Department of Health NT
PO Box 40596, Casuarina, NT 0811

Telephone: (08) 8922 7341
Fax: (08) 8922 7200
Email: poisonscontrol@nt.gov.au
Web: www.health.nt.gov.au/Environmental_Health/Poisons_Control/

GLOSSARY

administration of medicine	The process of giving a dose of medicine to a resident or a resident taking a medicine.
adverse drug reaction	A response to a drug that is noxious and unintended, and occurs at doses normally used in humans for the prophylaxis, diagnosis, or therapy of disease, or for the modification of physiological function. Note that there is a causal link between a drug and an adverse drug reaction.
adverse medicine event	A particular type of adverse event where a medicine is implicated as a causal factor. This encompasses harm that results from the intrinsic nature of the medicine (an adverse drug reaction) as well as harm that results from medication errors or system failures associated with the manufacture, distribution or use of medicines.
alteration of oral dose form	The altering or crushing of oral tablets or capsules before administration to residents who have difficulty swallowing. The alteration is intended to assist administration and ensure that residents receive necessary medicines. Alteration of oral dose forms can have potentially unsafe consequences such as increased toxicity, decreased efficacy, altered palatability, and safety or stability concerns, including creating potential hazards to health care workers.
assistant in nursing/ personal care worker (however titled)	An unlicensed health care worker providing direct care in the aged care environment. Some workers may have completed vocational training. They are individually accountable for their own actions and accountable to the registered nurse and their employer for delegated actions.
carer	In the context of this document, carer means a family carer, a resident's representative, medical power of attorney or guardian.

complementary and alternative medicines (CAMs)	CAMs include herbal, vitamin and mineral products, nutritional supplements, homeopathic medicines, traditional Chinese medicines, Ayurvedic medicines, Australian Indigenous medicines, and some aromatherapy products regulated under the <i>Therapeutic Goods Act 1989</i> . Other terms sometimes used to describe CAMs include ‘natural medicines’ and ‘holistic medicines’.
consent	The procedure whereby residents consent to, or refuse, an intervention based on information provided by a health care professional regarding the nature and potential risks (consequence and likelihood) of the proposed intervention.
consumer medicine information (CMI)	Brand-specific leaflets produced by a pharmaceutical company in accordance with the Therapeutic Goods Regulations to inform consumers about prescription and pharmacist-only medicines. Available from a variety of sources, e.g. enclosed with the medicine package, supplied by a pharmacist as a leaflet or computer printout, provided by a doctor, nurse or hospital, or available from the pharmaceutical manufacturer.
cytotoxic	Toxic to cells, cell killing. Any agent or process that kills cells. Chemotherapy and radiotherapy are forms of cytotoxic therapy.
dose administration aid (DAA)	A device or packaging system such as blister packs, bubble packs or sachets for organising doses of medicines according to the time of administration.
drug use evaluation (DUE)	Drug use evaluation (DUE) is a quality improvement activity to improve quality use of medicines (QUM) and health outcomes. DUE is medicine or disease specific and involves monitoring and reviewing use of the medicine, evaluating and comparing it with best practice guidelines, and using multifaceted interventions to improve use and overall patient care—this cycle is repeated as often as necessary to achieve set goals.

enrolled nurse

A person who has completed the prescribed educational preparation, demonstrated competence for practice, and is registered by the Nursing and Midwifery Board of Australia to practise as an Enrolled Nurse, under the *Health Practitioner Regulation National Law Act 2009*, and its Regulations.

high risk medicines

High risk medicines have a heightened risk of causing injury or harm even when used as intended and especially if they are misused or used in error. High risk medicines include:

- medicines with a narrow therapeutic index (i.e. a small difference between therapeutic and toxic doses);
- medicines with a high risk of serious harm when administered via the wrong route or when other system errors occur; and
- medicines which may be misused or abused such as narcotics.

Examples of high risk medicines include anti-coagulants, digoxin, chemotherapy and cytotoxic agents, insulin, potassium and other electrolytes, narcotics and other sedatives. The use of high risk medicines requires careful monitoring. Error rates with these medicines are not necessarily higher than with any other medicines, but when problems occur, the consequences can be severe.

medical practitioner

A person who has completed the prescribed educational preparation, demonstrated competence for practice, and is registered by the Medical Board of Australia to practise as a Medical Practitioner, under the *Health Practitioner Regulation National Law Act 2009*, and its Regulations.

This includes a general practitioner, medical specialist, consultant medical practitioner, or hospital medical officer.

medication advisory committee	A group of advisors to the RACF who provide medication management leadership and governance, and assist in the development, promotion, monitoring, review and evaluation of medication management policies and procedures that will have a positive impact on health and quality of life for residents.
medication chart	Provides a record of the prescriber's clinical intention for a resident's treatment, an order for the pharmacy supply of a resident's medicine, and a record of administration of the medicine to the resident.
medication incident	Events that could have or did cause the resident harm, and where medicine is likely to have been a contributing or causal factor. Medication incidents may be the result of error or system failure in the processes for prescribing, dispensing and administration of medicines. Most do not cause any harm; those resulting in harm are called Adverse Medicine Events.
medication management	Medication management occurs at both individual and services levels: It includes: <ul style="list-style-type: none">• how medicines are selected, ordered and supplied;• how people take medicines or are assisted to take them;• how medicines use is recorded and reviewed;• how medicines are stored and disposed of safely; and• how medicines use is supported, monitored and evaluated.

medication reconciliation	The formal process of obtaining and verifying a complete and accurate list of each resident's current medicines including prescription, over-the-counter and complementary and alternative medicines. The list is compared with the medicines ordered to identify and resolve any discrepancies with the prescriber. Any changes are documented. Verified information is transferred to the next care provider and the resident.
medication review	A structured and collaborative examination of a resident's medicines with the objective of reaching an agreement with the resident about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste.
medicine	A substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease or otherwise enhancing the physical or mental welfare of people. Includes prescription and non-prescription medicines, including complementary health care products, irrespective of the administered route.
medicines list	Medicines lists are records designed to help consumers keep an up-to-date record of all their medicines. Examples include Medicines List a free wallet-sized list produced by the NPS: Better Choices, Better Health and MediList produced by the Department of Veterans' Affairs Health.
non-prescription medicine	Medicines available without prescription. Examples are cough mixtures, simple analgesics and antacids. Some can be sold only by pharmacists ('Pharmacist Only') or in a pharmacy ('Pharmacy Only'); others can be sold through non-pharmacy outlets such as supermarkets. Also known as 'Over-the-Counter' (OTC) medicines.
nurse-initiated non prescription medicine	Involves the selection and administration of medicine/s by a registered or enrolled nurse from a list of non-prescription medicines approved by the RACF, undertaken when the need arises and with the prior agreement of the attending medical practitioner.

nurse practitioner	A registered nurse endorsed by the Nursing and Midwifery Board of Australia to function autonomously and collaboratively in an advanced and extended clinical role as a Nurse Practitioner, under the <i>Health Practitioner Regulation National Law Act 2009</i> , and its Regulations.
nurse prescribing	Refers to the legislated authority of nurse practitioners who are permitted and qualified to prescribe independently in accordance with relevant state, territory or national legislation, and take the responsibility for the clinical assessment of the patient, establishing a diagnosis and the clinical management required.
patient medication profile (PMP)	A patient medication profile (PMP) is a comprehensive summary of all regular medicines taken by a patient, and is intended to promote better understanding and management of medicines by consumers, as well as improve communication between consumers and their health care professionals.
personally controlled electronic health record (PCEHR)	The personally controlled electronic health record (PCEHR) system is being developed as part of the national e-health program. A PCEHR is a secure, electronic record of a person's medical history, stored and shared in a network of connected systems. The PCEHR brings key health information from a number of different systems together and presents it in a single view.
pharmacist	A person who has completed the prescribed educational preparation, demonstrated competence for practice, and is registered by the Pharmacy Board of Australia to practise as a pharmacist, under the <i>Health Practitioner Regulation National Law Act 2009</i> , and its Regulations. An 'Accredited Pharmacist' for medication reviews in RACFs is a registered pharmacist who has completed specified education programs or examinations approved by the Australian Association of Consultant Pharmacy or the Society of Hospital Pharmacists Australia.
polypharmacy	The concurrent use of five or more medicines.

prescriber	A health care professional who is authorised by legislation to issue a prescription for the supply of medicines.
quality use of medicines (QUM)	The National Strategy for Quality Use of Medicines is part of the National Medicines Policy (2000). QUM involves selecting management options wisely, including non-medicine alternatives; choosing suitable medicines if a medicine is considered necessary; and using medicines safely and effectively to get the best possible results.
Quality Use of Medicine (QUM) services	Under the Fifth Community Pharmacy Agreement (2010–2015), all Australian Government funded aged care facilities can enter into a QUM Service Agreement with an approved service provider. Approved Pharmacists are funded to provide services which focus on improving practices and procedures relating to QUM in RACFs. These QUM services can include medication advisory activities, education and continuous improvement.
resident	Under the Quality of Care Principles 1997, a care recipient who is provided with care through a residential aged care service.
residential aged care facility	A special-purpose facility that provides accommodation and other types of support, including assistance with day-to-day living, intensive forms of care, and assistance towards independent living, to frail and aged residents. Facilities are accredited by the Aged Care Standards and Accreditation Agency Ltd to receive funding from the Australian Government through residential aged care subsidies.
residential care	Personal and/or nursing care provided to a person in a residential aged care facility (RACF) in which the person is also provided with accommodation that includes meals, cleaning services, furniture and equipment.

registered nurse A person who has completed the prescribed educational preparation, demonstrated competence for practice, and is registered by the Nursing and Midwifery Board of Australia to practise as a registered nurse, under the *Health Practitioner Regulation National Law Act 2009*, and its Regulations.

standing order Legal written instructions for the administration of medicines by an authorised person. The authorised person must have a valid and current written instruction for the specific use of the standing order. A standing order is NOT the same as a 'when required' (PRN) order.

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www.health.gov.au

All information in this publication is correct as at September 2012