



Australian Government

**Department of Health
and Aged Care**

Medication management in the community

GUIDING PRINCIPLES

National quality use of medicines



About these Guiding Principles

These Guiding Principles are intended only as a guiding document. They are not prescriptive.

The document sets out recommended parameters and procedures for medication management in the community.

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

The Guiding Principles are based on current best practice and available evidence and are intended to be applicable to all community-based settings where people receive medicines-related advice, care and support. Their application must consider relevant national, state and territory legislative requirements, profession-specific licensing/registration, codes of practice, guidelines and standards, and relevant accreditation standards and requirements.

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- ▶ May Shaw Health and Wellbeing Facilities
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- ▶ National Aboriginal Community Controlled Health Organisation (NACCHO)
- ▶ National Prescribing Service (NPS MedicineWise)
- ▶ National Disability Insurance Scheme Quality and Safeguards Commission
- ▶ NSW Clinical Excellence Commission
- ▶ NSW Ministry of Health
- ▶ NSW Nurses and Midwives’ Association
- ▶ Occupational Therapy Australia
- ▶ Pharmacy Board of Australia
- ▶ Pharmacy Guild of Australia
- ▶ Pharmaceutical Defence Limited
- ▶ Pharmaceutical Society of Australia
- ▶ Pharmeducation
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- ▶ Queensland Nurses and Midwives Union
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Introduction

Guiding Principles

These *Guiding Principles for Medication Management in the Community* (2022 Ed.) build on the previous edition published in 2006, and promote practice that keeps the individual receiving care at the centre of an integrated health system.

Related publications

Users of *Guiding Principles for Medication Management in the Community* should be aware of these other closely related publications, and refer to them as needed:

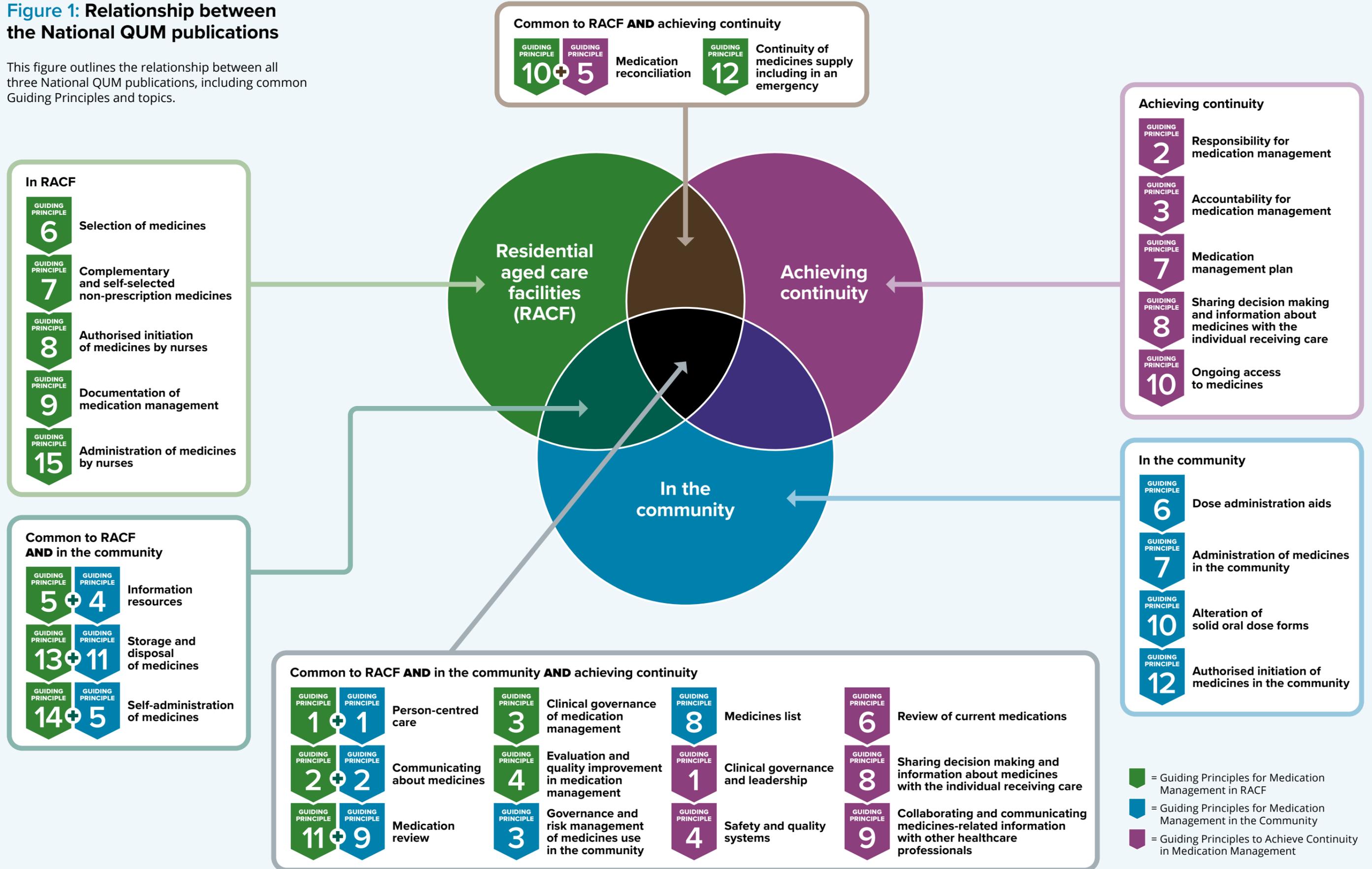
- ▶ [*Guiding Principles to Achieve Continuity in Medication Management*](#)
- ▶ [*Guiding Principles for Medication Management in Residential Aged Care Facilities*](#) and its 'supplement' [*User Guide: Role of a Medication Advisory Committee*](#)
- ▶ [*Glossary for the Guiding Principles and User Guide*](#).

Figure 1 outlines the relationship between all three National QUM publications.



Figure 1: Relationship between the National QUM publications

This figure outlines the relationship between all three National QUM publications, including common Guiding Principles and topics.



Purpose and scope of the Guiding Principles

Use of medicines is the most common intervention in health care. Consequently, medicines-related problems can occur at any stage during their prescription, dispensing and supply, as well as when being used by or administered to individuals.¹

The term 'medicine' covers a broad range of products that are used to prevent, treat, monitor, or cure a disease.² This includes but is not limited to prescription, complementary and non-prescription medicines.

Those involved in the prescription, dispensing, supply and support for a person's medicines needs should ensure safe and quality medication management. This includes healthcare providers moving between the community and other healthcare settings.

The *Guiding Principles for Medication Management in the Community* (the Guiding Principles) build on the 2006 edition of the guiding principles and are underpinned by Australia's National Medicines Policy (NMP). The NMP aims to create the environment in which 'appropriate structures, processes and accountabilities enable medicines and medicines-related services to be accessible in an equitable, safe, timely, and affordable way'.³ One of the four objectives of the NMP is the 'Quality use of medicines (QUM) and medicines safety'. In 2019, 'QUM and Medicines Safety' was declared Australia's 10th National Health Priority. The Guiding Principles promote a QUM and person-centred approach for medication management in the community consistent with the NMP. A QUM approach means:

- ▶ Selecting medicines management options appropriately
- ▶ Choosing suitable medicines, if a medicine is considered necessary
- ▶ Using medicines safely and effectively to get the best possible results.⁴

Applying a QUM and medicines safety approach aims to maximise the benefits and minimise the risks of harm from the use of medicines. Applying a person-centred approach that is respectful and responsive to the needs of Australia's diverse population is essential to achieve this aim.

The Guiding Principles promote safe, quality use of medicines and medication management within the community. They also promote a person-centred partnership and systems-based approach when support is being provided to people living at home. Sound governance of medication management is fundamental.



Medicines use and medication management need to be:

- ▶ Linked to the community healthcare provider's continuous quality improvement and risk management programs
- ▶ Supported by information, and education and training strategies provided by the community healthcare provider for its employees.

Supports for medication management in the community will include a range of health, aged care and community healthcare providers – such as general practice, community pharmacy, in-home support programs (however titled), community nursing, home-based cancer care, palliative care and disability care and support providers.

These Guiding Principles are intended to:

- ▶ Assist service providers in developing or evaluating policies, procedures and guidelines
- ▶ Support those involved in assisting people in their homes
- ▶ Support people in managing their own medicine(s)
- ▶ Guide healthcare professionals when applying and evaluating professional practice standards or guidelines.

These Guiding Principles are applicable across all age groups, and may be particularly useful in the medication management of people on multiple medicines.

The Guiding Principles are intended for use by all QUM partners, including by governments (Australian, state, territory and local), healthcare professionals, volunteers, and individuals, their carers and/or family, and substitute decision-makers.

The following groups could also use these Guiding Principles:

- ▶ Consumer organisations
- ▶ Professional organisations and regulatory authorities
- ▶ Educational organisations.

Some community-based services such as respite centres and transitional care facilities need to use the *Guiding Principles for Medication Management in Residential Aged Care Facilities* and ***Guiding Principles to Achieve Continuity in Medication Management***.

The Guiding Principles may not be applicable in all rural and remote settings as they may not address the complexities in these settings. However, their broad approach could help in establishing best-practice policies, procedures and guidelines for medication management in these settings.



Development of the Guiding Principles

This document is a revision of the *Guiding Principles for Medication Management in the Community* published by the (former) Australian Pharmaceutical Advisory Committee in June 2006.

In 2021, the (former) Australian Government Department of Health engaged the Australian Commission on Safety and Quality in Health Care to review and update the 2006 edition, in consultation with stakeholders.

The review process involved:

- ▶ Engagement of the University of South Australia (UniSA) to undertake analysis of relevant documents and published literature

- ▶ Identification of current best-practice evidence and areas of importance in QUM and medication management within the community
- ▶ Public consultation with over 80 peak organisations, and experts, involved in medication management
- ▶ Analysis of relevant documents and published literature
- ▶ Targeted consultations with consumers and primary care practitioners including prescribers, registered nurses and pharmacists.

The Australian Commission on Safety and Quality in Health Care was supported by a project advisory group, which provided strategic and practical advice to inform the revision.



The importance of improving medication management

Continuing change and developments have occurred within the community in medicines use and medication management since the 2006 edition of the Guiding Principles. At that time, a higher proportion of people would have lived in residential aged care. Today, more people can continue to live in their own homes with extra supports. In addition, peoples' medication management needs have become more complex. Evidence shows that:

- ▶ Around 250,000 hospital admissions annually are a result of medicines-related problems¹
- ▶ Around 400,000 additional presentations to emergency departments are likely to be due to medicines-related problems¹
- ▶ Over 90% people have at least one medicine-related problem post-discharge from hospital¹
- ▶ One in five people are suffering an adverse reaction from a medicine at the time they receive a Home Medicines Review (HMR)¹
- ▶ Almost one in four older people prescribed medicines cleared by the kidneys are prescribed an excessive dose¹
- ▶ The prevalence of polypharmacy (use of five or more unique medicines) in Australians 70 years and older had increased from 33.2% in 2006 to 36.2% in 2017 amongst Pharmaceutical Benefits Scheme (PBS) concession cardholders.⁵

Refer to the **Appendix: Background information** for further details on the importance of improving medication management in the community, including:

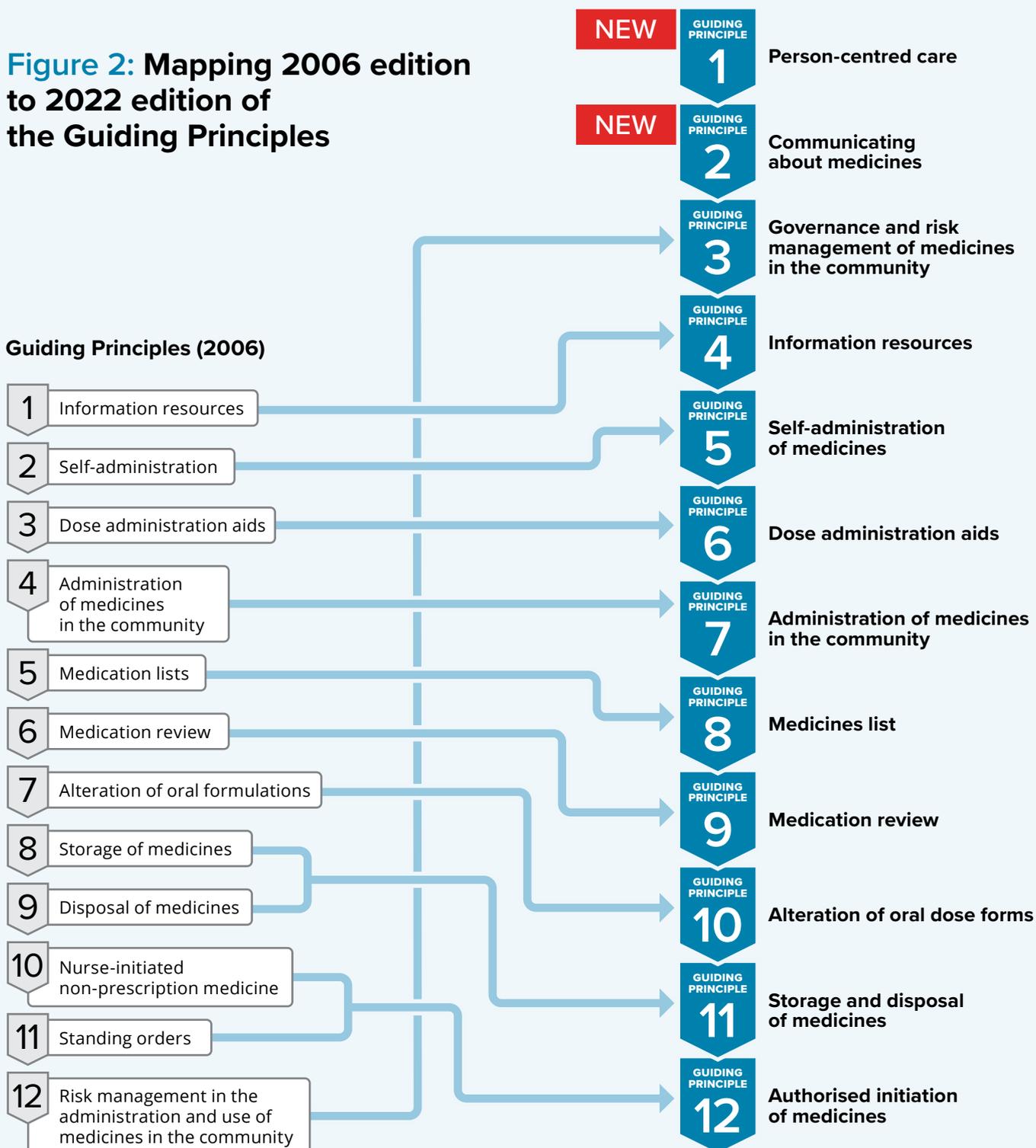
- ▶ Emerging areas of importance in medication management
- ▶ Australia's Primary Health Care 10 Year Plan 2022–2032
- ▶ Communication and health literacy
- ▶ Digital health
- ▶ Non-medical prescribing or initiation of medicines
- ▶ Person-centred care
- ▶ Pharmacists
- ▶ QUM and medicines safety
- ▶ Rural practice
- ▶ Support and initiatives.

Summary of changes

Content for these Guiding Principles (2022 Ed.) was informed by the review process described under the **Development of the Guiding Principles**. This resulted in new numbering, naming and

configuration to a total of 12 Guiding Principles, including two new overarching Guiding Principles. The mapping of the revised Guiding Principles is illustrated in **Figure 2**.

Figure 2: Mapping 2006 edition to 2022 edition of the Guiding Principles



How to use the Guiding Principles

Each of the 12 Guiding Principles has:

- ▶ A heading
- ▶ A statement of each Guiding Principle
- ▶ An explanatory note – summary and intent
- ▶ Key terms – with background, context and additional information
- ▶ Action items for the providers of community healthcare services, the healthcare professional(s) and the individual, their carer and/or family
- ▶ Some reflective questions.

A consolidated list of suggested **Resources** are included for each of the Guiding Principles.

Guiding Principles 1–3 set the overarching requirements for the effective implementation of the remaining Guiding Principles 4–12.

Each Guiding Principle should be read in conjunction with the supporting information, which includes further explanation of each principle and details key tasks and strategies to support its implementation.

Throughout these Guiding Principles, the responsibility for the action items refers to:

- ▶ **The providers of community healthcare services** – Community-based healthcare services – including healthcare workers (however titled), such as those supporting people with disabilities or chronic disease or providing end-of-life care.
- ▶ **Healthcare professionals** – A trained healthcare professional who provides direct clinical care to individuals. Healthcare professionals may provide care within a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They include nurses, midwives, medical practitioners, pharmacists, allied health professionals and other healthcare professionals who provide health care, and students who provide health care under supervision.
- ▶ **The individual, their carer and/or family** – An individual who has used, or may potentially use, healthcare services, or is a carer and/or family member for an individual using healthcare services in the community. Depending upon the individual's circumstances this will also include substitute decision-makers.

Roles and responsibilities in medication management

The prescription, supply and administration of medicines is strictly regulated. This is to maintain 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 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.

Healthcare professionals who are authorised by legislation to issue a prescription for the supply of medicines are referred to as prescribers, and include doctors, dentists, optometrists, midwives and nurse practitioners.

Registered nurses are qualified and legally authorised to administer medicines under the ***Health Practitioner Regulation National Law Act 2009***⁶ and relevant state/territory legislation and regulation. Enrolled nurses work under the direction and supervision of registered nurses.

In some jurisdictions, assistants in nursing or personal/home/disability or other categories of care workers (however titled), perform medicines-related tasks. They must do so in accordance with state or territory legislation, regulations, and relevant policies 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.

The individual receiving care within the community, and their carer, have both rights and responsibilities in health care, as described in the ***Australian Charter of Healthcare Rights***⁷, the ***Charter of Aged Care Rights***⁸ and the ***Carer Recognition Act 2010***⁹. 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 healthcare functions and services covered by the above-mentioned charters.

In addition, consumer protections such as the ***Privacy Act 1988***¹⁰ and associated ***Privacy Principles***¹¹ apply to personal information – for example, as contained in a medication chart (paper-based or electronic) or on a prescription medicine label. State or territory legislative requirements may also apply – for example, in the provision of advance 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 and medicines safety requires consideration of how each partner group can actively contribute and participate. An interdisciplinary and collaborative approach to medication management is fundamental to ensuring QUM and medicines safety.

The Guiding Principles

GUIDING PRINCIPLE

1

Person-centred care

All those involved in a person's medicines management provide person-centred care. This includes respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, informed consent and involvement of a person's carer and/or family. People have the right to partner in their care to the extent that they choose.

GUIDING PRINCIPLE

2

Communicating about medicines

All medicines-related communications consider health literacy, are 'person-centred' and collaborative, and facilitate shared decision-making, advocacy and self-determination.

GUIDING PRINCIPLE

3

Governance and risk management of medicines use in the community

Healthcare professionals, care workers and service providers work together with individuals and/or their carers to prevent and/or manage risks, incidents and adverse reactions associated with medicines use in the community.

GUIDING PRINCIPLE

4

Information resources

All those involved with the prescribing, dispensing, administration, and handling of medicines in the community should have access to current and evidence-based medicines-related information tools and resources.

People, their carers and/or families should also have access to plain language, accurate, evidence-based, trusted and reliable medicines-related information.

GUIDING PRINCIPLE

5

Self-administration of medicines

People are encouraged to have an active role and have the right to make choices and decisions about their care, and where necessary, are supported to maintain maximum independence for as long as possible. This includes managing their own medicines in a safe and effective way.

GUIDING PRINCIPLE

6

Dose administration aids

Dose administration aids (DAAs) should be used to support individuals to remain independent and reduce the risk of administration error. They should only be used when a person is assessed as having a specific problem managing or safely administering their own medicines.

GUIDING PRINCIPLE

7

Administration of medicines in the community

People who live at home should have access to, and receive, suitable information and/or assistance so that they can take their medicines safely and effectively. Healthcare professionals, care workers and healthcare service providers all play an important role.

GUIDING PRINCIPLE

8

Medicines list

Everyone taking one or more medicines should be encouraged and supported to maintain an up-to-date list of all their medicines. This list should be available and easily accessible to the individual and all those involved in their care.

GUIDING PRINCIPLE

9

Medication review

A person has the right for their medicines to be routinely and regularly reviewed with members of their healthcare team. These reviews should be conducted in accordance with relevant professional responsibilities, practice standards and guidelines.

GUIDING PRINCIPLE

10

Alteration of solid oral dose forms

Alteration of oral dose forms of medicines, such as crushing tablets, should be avoided. However, if a person is suffering from swallowing difficulties:

- ▶ Suitable alternative formulations (or medicines) should be sought
- ▶ The person should be provided with the information and help they need to ensure their medicines can be administered safely and effectively.

GUIDING
PRINCIPLE

11

Storage and disposal of medicines

All those using medicines in the community should store medicines in a manner that:

- ▶ Maintains the quality of the medicines
- ▶ Minimises wastage
- ▶ Safeguards the person, the person's family and visitors in their home.

Unwanted, ceased or expired medicines should be disposed of safely to avoid accidental harm and misuse in a sustainable and environmentally appropriate manner.

GUIDING
PRINCIPLE

12

Authorised initiation of medicines in the community

In accordance with national, state or territory legislation, only those authorised to do so should initiate medicines upon a person's request for the relief of minor symptoms or conditions/ailments.

Healthcare service providers should develop policies, procedures and guidelines on:

- ▶ Initiation of prescription and non-prescription medicines
- ▶ Use and review of prescription medicines treatment protocols.



GUIDING PRINCIPLE

1

Person-centred care

All those involved in a person's medicines management provide person-centred care. This includes respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, informed consent and involvement of a person's carers and family. A person has the right to partner in their care to the extent that they choose.

Summary and intent

Every person has the right to make choices and decisions about their care.

In accordance with the [Australian Charter of Healthcare Rights](#)⁷, the delivery of each person's care should be respectful of and responsive to their specific needs, preferences and values.

Communication should also be respectful and tailored to meet a person's specific needs. Understanding a person's level of health literacy (including digital health literacy) is recognised as an important factor in improving the safety and quality of their medication management (refer to **Guiding Principle 2: Communicating about medicines**).

For healthcare professionals, a person-centred approach to care means:

- ▶ Partnering with the person in their care, and treating the person with dignity and respect
- ▶ Involving the person in their own care by encouraging participation and collaboration
- ▶ Meeting their needs for information by sharing and supporting their understanding of information
- ▶ Tailoring information to match their health literacy and specific needs

- ▶ Sharing the decision-making about their treatment options (including whether using a medicine is the best option)
- ▶ Providing culturally safe care that is supportive and responsive to the knowledge, beliefs and values of Aboriginal and Torres Strait Islander peoples, and others.

Each person receiving care (including their carer, family and/or substitute decision-maker) within the community is:

- ▶ Asked about their medicine needs, preferences and medicine-taking behaviours, including prescription, complementary and non-prescription medicines
- ▶ Involved in sharing decisions about choice of medicine, including non-pharmacological alternative treatments
- ▶ Provided with information that is easy to understand, accessible and able to meet their specific needs
- ▶ Provided with information about the benefits and risks of proposed treatment options to be able to give informed consent
- ▶ Supported in a safe, respectful and appropriate manner to navigate the assessment and consent processes involved in the use of medicines, particularly in the context of high-risk medicines

- ▶ Informed about the costs associated with medicines use, including any additional charges from the supply of devices and medicine dose administration aids
- ▶ Assisted to administer their own medicines, where it is safe for the person and those around them
- ▶ Encouraged and supported to give feedback about their medication management.

The individual's carer, family and/or substitute decision-maker must be involved in developing, implementing and reviewing individualised care plans for individuals with reduced capacity to make decisions for themselves – for example, people living with cognitive impairment.

Depending on individual living arrangements and state of health, an individual may be provided with devices to monitor or measure their heart rate, blood pressure, breathing and oxygen saturation levels. Telehealth, for instance, telephone or video conferencing is used to connect people to their healthcare providers and builds the capacity of the individual (and their carer) to self-manage in partnership with their care provider.

Key terms

All technical terms in these Guiding Principles are defined in the *[Glossary for the Guiding Principles and User Guide](#)*. This section provides background, contextual and additional information on the use of key terms in the specific context of this Guiding Principle.

Partnership

Partnering with individuals is about actively working with those who use the healthcare system to ensure that care is safe, high-quality and meets their needs. It involves treating individuals with dignity and respect, sharing information, and encouraging participation and collaboration. Working in partnership and fostering a person-centred approach to care can help improve the safety and quality of care.

From a quality use of medicines perspective, partnership is a working relationship where the risks and benefits of medicine treatment options are shared and the principles of equity, openness, mutual benefit, courage and diversity are in evidence.

Implementation – key tasks and strategies

This Guiding Principle is applied across the *Guiding Principles for Medication Management in the Community*.

Resources



A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

Reflective questions



How does the healthcare service provider ensure that each person receiving care is well informed and involved in the decision making about their care and treatment with medicines?



What medicines-related information is provided to a person receiving care and their carers or family?



How is medicines-related information tailored to a person's specific needs?



How is a person receiving care involved in the decision-making and consent processes, about the medicines that are being prescribed?



How is a person receiving care in their home involved in the decision-making and consent processes, about the medicines that are being administered?



How are carers, family and/or substitute decision-makers included in the decision-making about a person's treatment options and choices?

Communicating about medicines

All medicines-related communications consider health literacy, are 'person-centred' and collaborative, and facilitate shared decision-making, advocacy and self-determination.

Summary and intent

Communication about medicines with the individual receiving care (along with their carer, family and/or substitute decision-maker) is:

- ▶ Person-centred, collaborative, respectful and tailored to their health literacy and specific needs (refer to **Guiding Principle 1: Person-centred care**)
- ▶ Culturally safe, which includes personable two-way communication and trusting relationships
- ▶ Timely, purpose-driven and effective
- ▶ Supportive of the safe and quality use of medicines across the entire medication management pathway pictured in **Figure 3**.

Medicines documentation, whether paper-based, electronic or a hybrid arrangement, should support continuity of medicines supply (refer to **Guiding Principles to Achieve Continuity of Medication Management**).

Community healthcare service providers should set up and maintain systems and processes to support effective communication:

- ▶ With the individual, their carer and/or family and substitute decision-maker
- ▶ With and between healthcare professionals, including specialist healthcare providers, pharmacists, community pharmacy and other service providers

- ▶ Across the group of healthcare service providers (if relevant).

These systems should be used by the relevant healthcare workforce to communicate effectively and collaboratively, and to ensure safe and quality use of medicines.

Systems and processes support:

- ▶ The use of communication tools or services, for instance, translation, visual aids or hearing services. This includes offering individuals and their carers and/or families who use English as a second language – for instance, Aboriginal and Torres Strait Islander peoples, access to interpreters, ideally medically trained; where possible they are offered translated resources
- ▶ Correct identification when people are administered their medicines
- ▶ Clinical handover of information about a person's medicines, including at transitions of care
- ▶ Escalation of care when a person's health status changes
- ▶ The individual and their carer, family and/or substitute decision-maker being able to raise issues, provide feedback or make a complaint about their medicines (refer to **Guiding Principle 3: Governance and risk management of medicines use in the community**).

Implementation – key tasks and strategies

This Guiding Principle is applied across the *Guiding Principles for Medication Management in the Community*.

Resources



A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

Reflective questions

-  What process do healthcare professionals, including medical specialists, pharmacy, allied health and other service providers use to effectively communicate with an individual (along with their carer and/or family and person with responsibility) about their medicines?
-  How do healthcare service providers ensure use of ‘inclusive language’ when communicating about medicines?
-  What systems or processes are in place to ensure that a person’s medicines-related information is available – for instance, at transitions of care – and communicated to all those involved in their care?
-  How does the healthcare service provider collect and use feedback (including complaints) to improve communication about medicines?



Figure 3: Medication management pathway



Adapted from the Australian Commission on Safety and Quality in Health Care *National Safety and Quality Health Service Standards Guide for Hospitals*¹² 'Medication Safety Standard'.

Governance and risk management of medicines use in the community

Healthcare professionals, care workers and service providers work together with individuals and/or their carers to prevent and/or manage risks, incidents and adverse reactions associated with medicines use in the community.

Summary and intent

According to the [Australian Charter of Healthcare Rights](#)⁷, everyone has the right to receive safe and high-quality care, healthcare services and treatment that meets their needs; have their privacy respected; and have their concerns (including complaints) addressed in a transparent and timely manner (refer to **Guiding Principle 1: Person-centred care**).

Healthcare service providers are responsible for having systems in place that meet national, state or territory legislative requirements and result in a safe system for medication management in the community. These systems are covered within each of the *Guiding Principles for Medication Management in the Community*.

This Guiding Principle provides advice on systems that can reduce or eliminate the risk of medication incidents or errors. It focuses on:

- Governance processes that should be in place when a medication incident occurs, is suspected to have occurred, or where a medication incident has been averted (referred to as a 'near miss')
- Risk management systems to minimise the likelihood of medication errors and prevent their reoccurrence.

The Australian Commission on Safety and Quality in Health Care *Incident Management Guide*¹³ includes best-practice principles of incident management. They are applicable to clinical (including medication) incidents that occur in primary, secondary and community healthcare settings and outline the usual phases of incident management – from incident identification to lessons learnt. These include:

1. Identification
2. Immediate action to reduce risk and harm to the patient
3. Notification
4. Initial assessment and prioritisation
5. Analysis
6. Action
7. Feedback
8. System-wide learning and sharing.

Responding to medication incidents (including 'near miss' incidents) and complaints need to be included in a risk management policy that outlines the steps to be taken following a medication incident (or 'near miss'). The policy steps also need to cover:

- Providing a timely response to an individual's complaint
- Implementing measures aimed at preventing similar incidents from occurring.

Medication incidents can occur at numerous points, from the prescription or selection of a medicine to its ingestion. There are formal and informal safety and quality checks, aimed at preventing the risk of harm, at many points along the medication management pathway – for example, the prescriber using electronic prescribing and decision-support tools can alert them to an individual's medicine allergies; the pharmacist using dispensing software can flag medicines interactions during the dispensing process; the individual and/or their carer reading the consumer medicines information (CMI); and the healthcare professional administering the medicine.

The individual and their carer and/or family should be encouraged to provide feedback on the management of their medicines and provided advice on how to lodge a complaint or incident. They should also expect to receive feedback on and satisfactory resolution of their medicines-related complaints.

People can experience adverse reactions, including side effects or a suspected allergic response, to medicines and need to report these as soon as possible to their healthcare professional. Community healthcare service providers also need to have mechanisms to alert the person's primary healthcare provider (for instance, their GP) and/or pharmacist if an individual, their carer or family raises a concern about an adverse reaction to any of their medicines.

Key terms

All technical terms in these Guiding Principles are defined in the *Glossary for the Guiding Principles and User Guide*. This section provides background, contextual and additional information on the use of key terms in the specific context of this Guiding Principle.

Clinical governance

A healthcare service provider's clinical governance framework should describes the safety and quality systems and processes that need to be in place to ensure the delivery of safe, high-quality health care. Robust clinical governance frameworks are increasingly required to provide assurances to the community that a healthcare service meets expected standards for safety and quality.

Developed as a resource to support health services implement the National Safety and Quality Health Service (NSQHS) Standards, the **National Model Clinical Governance Framework**¹⁴ describes key concepts, roles and responsibilities relating to clinical governance that are broadly applicable. The *Clinical Governance Principles for Pharmacy Services*¹⁵ recognises and has contextualised this approach to clinical governance within pharmacist-led services. Community healthcare service providers implementing the **National Safety and Quality Primary and Community Healthcare Standards**¹⁶ will establish their own clinical governance frameworks.

Most community pharmacies in Australia are accredited against **AS85000 Quality Care Community Pharmacy Standard**¹⁷ which contains some elements of clinical governance, including risk management and staff management. The following services are included under the Pharmacy Programs Administrator:

- **Medication adherence**¹⁸
- **Medication management**¹⁹
- **Aboriginal and Torres Strait Islander specific programs.**²⁰

The **standards for general practices**²¹ include requirements for clinical governance and participating in continuous quality improvement. These are key issues for the purpose of general practice accreditation which is incentivised through the Australian Government **Practice Incentives Program** (PIP).²²

The Australian Government **Commonwealth Home Support Programme**²³ provides funding to aged care service providers within a clinical governance framework. These providers have certain **responsibilities**²⁴ about:

- The quality of care they provide
- The user rights of people receiving care
- Being accountable for the care provided.

Risk management and quality improvement

A risk assessment needs to take place at regular intervals, especially when a process change is implemented, and when an adverse incident occurs – for instance, following a medication incident or ‘near miss’.

Risks associated with medicines need to be managed within a risk management framework. This includes applying a continuous quality improvement (CQI) or cyclical approach to improving processes and outcomes that involves structured problem solving. There remains a focus on individuals and the need for open disclosure, and collaboration when designing and implementing improvement strategies.

A CQI program needs to be people-focused, active and peer-based. It provides the opportunity for feedback about people’s experiences of the quality of care and services being provided, as well as making appropriate changes in practice that maintain and improve quality of care and ultimately healthcare outcomes. Discussing a medication incident openly with individuals provides the opportunity to explore contributing factors, likely outcomes and options to resolve, as well as offering an apology.

Principles that underpin a CQI approach include:

- ▶ Improvement oriented
- ▶ Meets the needs of individuals and the community
- ▶ Decisions to improve systems and processes driven by analyses and data
- ▶ A multidisciplinary team approach to problem solving and quality improvement.

Healthcare professionals and care workers (however titled) can use CQI processes to measure and compare their performance against professional standards.

Continuous quality improvement tools

Healthcare service providers should use or develop quality improvement tools which healthcare professionals and care workers should become familiar with and use. Various tools can be used and include:

- ▶ **Continuous improvement plans**²⁵
- ▶ Incident forms
- ▶ **Cause and effect diagrams**²⁶
- ▶ **Driver diagrams**²⁷ and **scatter plots**²⁸
- ▶ **Failure Mode and Effects Analysis (FMEA) tool**²⁹
- ▶ **Pareto charts**³⁰, **flow charts**³¹, **run charts**³² and **control charts**³³
- ▶ **Plan-Do-Study-Act (PDSA)**³⁴ worksheets.

A widely and internationally recognised CQI method or **model for improvement**^{35,36} is promoted by the **Institute for Healthcare Improvement (IHI)**.³⁷ The **IHI Quality Improvement Essentials Toolkit**³⁸ contains tools and templates that can be used with the **model for improvement**³⁵ which guides teams through the steps of:

- ▶ Identifying areas for improvement
- ▶ Setting measurable aims
- ▶ Identifying changes to the process of care that are likely to result in improvement
- ▶ Using repeated PDSA cycles and data analysis to plan and test changes.

Root cause analysis (RCA) is another quality improvement tool that is used when investigating a medication incident or ‘near miss’. **Additional information**³⁹ on RCAs, as well as state and territory incident management policies and guidelines, is available to help guide health professionals and community healthcare service providers.

The **Australian Open Disclosure Framework** (the Framework)⁴⁰ provides a nationally consistent basis for communication following unexpected healthcare outcomes and harm. This includes the management of medication incidents (including ‘near miss’ incidents). The Framework is designed so that patients are treated respectfully after adverse events and is intended for use by Australian health service organisations across all settings and sectors. It describes open disclosure practice and considerations that may affect local implementation and can be used to inform new, or review of existing, open disclosure policies, procedures or guidelines.

Reporting mechanisms and incident management

A report form or log (paper-based or electronic) can be used to document the details of a medication incident (or 'near miss') and commence an investigation process – determined by the severity or level of harm. If available, a comprehensive incident reporting system allows collation of incident reports and regular analysis and review of incidents and trends.

Alternatively, a generic medication incident reporting form or tool (paper-based or electronic) can be used. The report needs to include:

- ▶ The person's identifying information – for instance, their name
- ▶ The date the incident was identified (this could be later than the date of the incident)
- ▶ Date and time the incident occurred
- ▶ The name of the person reporting the incident and who was notified of the incident
- ▶ A description of the incident – including what happened
- ▶ A description of how the incident was managed
- ▶ If relevant, the outcome of the investigation, including the name of the investigator
- ▶ A description of any corrective actions – either planned or implemented – to prevent a recurrence.

Depending on the nature of the incident, as well as the healthcare service provider and funding arrangements, reporting may be required under additional frameworks, such as the **Serious Incident Response Scheme**.⁴¹

Implementation – key tasks and strategies

For the providers of community healthcare services

All healthcare service providers are responsible for:

- ▶ Establishing a clinical governance framework for medication management
- ▶ Developing and/or implementing suitable policies, procedures and guidelines for medication management
- ▶ Implementing a risk-management and CQI system to identify and investigate risks associated with medication management as well as
 - reporting and analysis
 - implementing strategies to prevent recurrence.

Healthcare service provider employees – for instance, care workers (however titled) – have a responsibility to report incidents, as well as complaints or concerns raised by individuals about their medicines. These should be recorded in their incident management system, so that these can be reviewed as part of a continuous quality improvement process.

It is recommended that all community healthcare service providers collect and analyse the medication incident and complaint data relating to their own service or organisation.

Examples of incident management or reporting systems are included in the **Resources** section for this Guiding Principle.

For healthcare professionals

All healthcare professionals (and their employees) are responsible for their own actions and need to report any medication incidents (including 'near miss' incidents), and document peoples' concerns or complaints. The process needs to be outlined in the healthcare service provider's organisational policies, procedures and guidelines and according to expected professional and/or profession-specific standards and guidelines.

Appropriate steps need to be taken, and a response provided to the individual making a complaint or that has been impacted by a medication incident (including a 'near miss' incident). For instance, the response needs to be timely and outline the measures that will, or have been implemented, to prevent a recurrence.

Healthcare professionals also have a responsibility to **report a problem or side effect**⁴² to the TGA if a person they are treating experiences a problem with a medicine, including suspected adverse reactions.

When providing medicines-related information, including when a prescriber or pharmacist might be counselling a person about their medicines, potential adverse effects from medicines should be discussed. CMI's are a suitable source of information on medicines' side effects to assist with this discussion.

For the individual, their carer and/or family

Those receiving care, their carer and/or family should be encouraged to provide feedback on the management of their medicines and provided advice on how to lodge a complaint or incident. They should also expect to receive feedback on and satisfactory resolution of their medicines-related complaints.

If an individual experiences side effects from medicines, in the first instance they should contact their GP and/or pharmacist as soon as possible. Additional available mechanisms for seeking advice or what to do in an emergency are described below.

Adverse Medicine Event Line

The **Adverse Medicine Event (AME) Line**⁴³ is also available for people to report and discuss adverse experiences with their medicines. The AME Line provides independent, accurate and evidence-based information. People can call if they suspect that their medicine(s) is causing a problem. People can report any reaction serious enough to have caused them concern – for instance, made them reluctant to continue using a medicine(s), or caused them to seek additional help, including admission to hospital. Errors with medicines can also be reported, whether or not they resulted in injury or harm.

The AME Line will also report deidentified medicines-related side effects to the **Therapeutic Goods Administration (TGA)**⁴⁴ for assessment to contribute to national efforts to make medicines safer for everyone. Individuals can also **report a problem or side effect**⁴² with a medicine, including prescription, complementary and non-prescription medicines and vaccines, directly to the TGA. Problems to report can also include concerns about counterfeit medicines, medicines packaging or storage, or medical devices.

The AME Line is not for emergencies.

Emergencies

In a life threatening emergency, people should dial Emergency Triple Zero (000) for Police, Fire or Ambulance.

For concerns arising from an overdose or suspected poisoning, individuals should call the **Poisons Information Centre**⁴⁵ on 13 11 26 from anywhere in Australia – available 24 hours a day, seven days a week.

Resources



A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

Reflective questions



How do community healthcare service providers collect and analyse the medication incident data relating to their own service or organisation?



How does the community healthcare service provider ensure satisfactory resolution of people's medicine-related complaints?



How do community healthcare service providers collaborate with prescribers and pharmacists to prevent, report and/or resolve medicines-related problems?

Information resources

All those involved with the prescribing, dispensing, administration, and handling of medicines in the community access current and evidence-based medicines-related information, tools and resources.

People, their carers and/or families should also have access to plain language, accurate, evidence-based, trusted and reliable medicines-related information.

Summary and intent

Quality and evidence-based medicines information supports safe and quality use of medicines (QUM).

The individual, their carer and/or family, or substitute decision-maker, as well as healthcare professionals, community healthcare providers and care workers (however titled) need to have access to relevant medicines-related information for optimal medication management. For instance, uses plain and inclusive language, and is evidence-based, trusted and reliable, or good quality, information.

The individual, their carer and/or family need information that:

- ▶ Is person-centred and tailored to meet the individual's health literacy needs (refer to **Guiding Principle 2: Communicating about medicines**)
- ▶ Supports decision-making about their medicines
- ▶ Supports informed consent
- ▶ Assists the person to manage their own medicines (refer to **Guiding Principle 5: Self-administration of medicines**).

All healthcare professionals need medicines-related information, tools and resources to support and guide their professional medication management responsibilities.

The provision of appropriate medicines-related information, especially when medicines are commenced and/or ceased, is important for the safe and quality use of medicines. This is particularly important at transitions of care – for example, when changes are made to a person's medicines during a recent hospital admission (refer to the ***Guiding Principles to Achieve Continuity of Medication Management*** for further information).

Having access to current, evidence-based and accurate information about medicines assists healthcare professionals provide the individual and/or their carer with appropriate information in a timely manner. This includes the provision of consumer medicines information (CMI) and advice about medicine use at the time of dispensing and counselling about a newly prescribed medicine.

Healthcare professionals should tailor their communication to a person's needs and preferences, including their level of understanding of how to take their medicines and what would happen if they do not. This should take into account the person's health literacy (including digital health literacy) and language skills, their cultural background and their medicines dose schedule or regimen (refer to **Guiding Principle 2: Communicating about medicines**).

Community healthcare service providers and care workers (however titled) who are supporting older people or those with special needs in the community, should consult with the person's pharmacist and/or primary healthcare provider (for instance, their GP) for further information about the medicines they might be taking.

Before relying on information found on websites listed in this and other Guiding Principles, users should carefully evaluate its accuracy, currency, completeness and relevance for their purposes, and should obtain appropriate professional advice relevant to their particular circumstances.

Access to good quality medicines-related information:

- ▶ Promotes informed decision-making about the benefits and risks of different treatment options
- ▶ Is essential to support informed consent
- ▶ Should be combined with good communication about medicines by healthcare professionals and community healthcare providers.

Key terms

All technical terms in these Guiding Principles are defined in the ***Glossary for the Guiding Principles and User Guide***. This section provides background, contextual and additional information on the use of key terms in the specific context of this Guiding Principle.

Plain language

Writing in plain language (or plain English) is a way of writing and organising information so that a person can read, understand and act on the information when they first read it.

Writing health information for consumers⁴⁶ is a fact sheet that describes how to review and improve content of locally developed written information.

Inclusive language

Language that is culturally appropriate and respectful of the diversity of Australia's peoples should be used. For example, the **Australian Government Style Manual**⁴⁷ provides guidance on how to create clear and consistent content when editing or writing with, for or about:

- ▶ Aboriginal and Torres Strait Islander peoples
- ▶ Age diversity
- ▶ Cultural and linguistic diversity
- ▶ Gender and sexual diversity
- ▶ People with a disability.

Implementation – key tasks and strategies

For the providers of community healthcare services

Community healthcare service providers need to ensure access (including online access) to medicines-related information, tools and resources that:

- ▶ Are current and evidence-based
- ▶ Enable the individual and their carer and/or family to be informed about their medicines and be involved in the decision making about their treatment options
- ▶ Support healthcare professionals and other care workers (however titled) to provide safe and quality use of medicines.

To ensure effective use of information resources, community healthcare service providers need to consider how to make the medicines-related resources readily accessible to different users, including after-hours and remotely.

Availability and provision of information to individuals should take account of the health literacy, level of understanding of medicines information, language skills, specific needs, and cultural sensitivities of the person seeking the information.

For healthcare professionals

Prescribers, pharmacists and registered nurses need to:

- ▶ Participate in the development and review of medicines-related policies, procedures and guidelines
- ▶ Access and use up-to-date evidence-based medicines-related information, decision-support tools and resources when
 - providing advice
 - prescribing, dispensing or administering medicines
 - making decisions to deprescribe medicines, or modify the dose or formulation of a medicine
- ▶ Discuss the benefits and associated risks of any medicines (including prescription, complementary and non-prescription medicines) before and during the decision-making process, and when informed consent is obtained
- ▶ Use consumer-specific information (such as CMI) to help inform individuals about their medicines
- ▶ Ensure any medicines-related information that is provided is in the most appropriate form and tailored to the specific needs of the individual, their carer and/or family – for instance, uses plain and inclusive language
- ▶ Document the provision of medicines-related information as a part of the consent process, within the person's healthcare record (paper-based or electronic), and/or on the medication chart (paper-based or electronic), within a general practice management system and/or patient notes within a community pharmacy dispensing system. This is particularly important in the context of high-risk medicines – for instance, psychotropic medicines.

For the individual, their carer and/or family

Medication safety is improved, and the risk of medication error and harm are reduced when an individual understands their medicines and has access to medicines-related information.

The individual, their carer and/or family and/or substitute decision-maker need to have access to information about treatment options so they are able to make informed choices about their medicines. This enables and supports shared decision-making conversations about their medicines (including the safe and effective use of

complementary and non-prescription medicines and any newly prescribed medicines) and better adherence to medicines-related treatment plans.

The information needs to be:

- ▶ Person-centred and tailored in a form that can be used and understood
- ▶ Sensitive to the person's specific needs – for example, culturally sensitive
- ▶ Appropriate for the person's level of health literacy
- ▶ Available in the person's preferred language
- ▶ In a format that is appropriate for the individual and their carer; using technology wherever possible, while acknowledging that some people will prefer paper-based materials and may require large print versions.

Information on how to access and find medicines-related information is available via **NPS MedicineWise**⁴⁸ – including finding trusted, reliable information; the active ingredients in medicines; and how to read CMI. This will equip the individual, their carer and/or family to discuss treatment options, including medicines use, as part of their care.

Medicines-related information needs to be available to support all stages of the medication management pathway and include:

- ▶ Pharmacological and non-pharmacological treatment options
- ▶ Potential benefits and possible side effects of medicines – for example, before deciding to prescribe or deprescribe
- ▶ Appropriate administration or self-administration of medicines – for example, to educate an individual on self-administration techniques, such as for inhalers.

The individual, their carer and/or family need to be discerning and seek advice when sourcing medicines-related information. Information sourced from websites should not be used as a substitute for professional healthcare advice and should not be used to self-diagnose, treat, cure or prevent disease or illness.

Resources



A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

Self-administration of medicines

People are encouraged to have an active role and have the right to make choices and decisions about their care, and where necessary, are supported to maintain maximum independence for as long as possible. This includes managing their own medicines in a safe and effective way.

Summary and intent

Those who are prescribed medicines should be encouraged to take or maintain an active role in managing their own medicines, including the self-administration of their prescription, complementary and non-prescription medicines. This responsibility can be important for the individual in maintaining a level of independence and control over making choices about their care.

It is important that all community healthcare professionals and care workers (however titled) respect the need for an individual to maintain and maximise their independence through the administration of their own medicines. However, review or assessment of a person's willingness and ongoing capacity to self-administer their medicines may be required, especially when there is a change in their health or cognitive status, or physical ability. An individual's carer and/or family or substitute decision-maker may need to temporarily support the individual or encourage them to seek assistance from their primary healthcare provider – for instance, their GP or pharmacist.

People may wish to only self-administer some of their medicines, such as oral dose forms, and might require a registered nurse (for example, a community nurse) to administer injections. Healthcare professionals and care workers (however titled) should support individuals in their choice to self-administer their own medicines.

Devices may be required and are used to facilitate and support safe self-administration of medicines. Whilst dose administration aids (DAAs) are the most common devices, others such as inhalers, spacers and pen devices are also used (refer to **Guiding Principle 6: Dose administration aids**).

A collaborative approach to addressing issues regarding self-administration of medicines is required to ensure an individual is able to safely manage their medicines at home. Carers, families, care workers, community and accredited pharmacists, community nurses, prescribers and other healthcare professionals all share a role in identifying any concerns about an individual's ability to manage their medicines. This includes during periods of acute illness, or 'sick days'.

Ongoing review of medication management should also occur in order to streamline medication management for the individual, their carer and/or family in their home, and facilitate their ability to administer their own medicines (refer to **Guiding Principle 9: Medication review**).

All community healthcare providers, healthcare professionals and care workers involved in an individual's care need to communicate with each other and the individual, their carer and/or family (refer to **Guiding Principle 2: Communicating about medicines**).

Key terms

All technical terms in these Guiding Principles are defined in the *Glossary for the Guiding Principles and User Guide*. This section provides background, contextual and additional information on the use of key terms in the specific context of this Guiding Principle.

Self-administration of medicines

Self-administration is when a person can take their own medicines.

Those who wish to administer their own medicines may need to be formally assessed to determine whether there is a risk to themselves or others, including the person's capacity to self-administer medicines safely.

Regular review or reassessment of a person's ongoing capacity to self-administer their medicines need to be conducted when there is a change in a person's health or cognitive status or physical ability.

Acute illness or 'sick days'

The risk of adverse events may increase during periods of acute illness due to comorbidities or medicine use (for example, gastroenteritis or diarrhoea)⁴⁹ or for acute exacerbations of a person's chronic illness – 'sick days'.

Some medicines may need to be temporarily suspended – for instance, diuretics, or the dose temporarily increased – for example, insulin. Factors to consider will include the type of medicine, its formulation, pharmacokinetics, duration of the acute illness and comorbidities.

Implementation – key tasks and strategies

For the providers of community healthcare services

Depending upon the level of support or assistance required, as many support strategies as possible should be trialled with an individual, their carer and/or family, before a healthcare professional – for instance, a community nurse, is engaged to manage and administer a person's medicines in their home (refer to **Guiding Principle 7: Administration of medicines in the community**).

Community healthcare providers (as well as care workers) need to encourage those taking medicines to talk to their prescribers and pharmacists about all the medicines they are currently taking.

Role of the care worker (however titled)

Care workers should monitor a person's medication management and if they suspect a person is suffering from any suspected adverse medicine events, they should be guided by their healthcare service provider's medication management policies, procedures and guidelines.

Should a care worker find that a person is having difficulty in self-administering their medicines, the care worker needs to alert their supervisor to the potential need for a formal review or assessment by the person's prescriber – for instance, their GP, or by a pharmacist. With the person's consent, their carer and/or family should also be advised. This includes the individual using DAAs to support self-administration of their medicines (refer to **Guiding Principle 6: Dose administration aids**).

Self-administration of imported medicines

Where a person has imported a medicine for their personal use, the assigned nurse or care worker will need to follow the service provider's policies and procedures on managing self-administration of imported medicines. As personally imported medicines will not be registered in Australia, they will not have been tested for safety and quality. It will be important for community healthcare services providers to seek advice from the person's prescriber or pharmacist about monitoring for possible signs of side effects from an imported medicine.

Self-administration of palliative care or pain medicines

In situations where palliative care or complex pain management is required – for instance, a syringe driver device or other system to relieve 'break-through pain', it might be necessary for an authorised healthcare professional (for example, palliative care nurse) to prepare an additional syringe for the individual or their carer to administer when the nurse is not available. The preparation and labelling of syringes containing Schedule 8 substances must comply with the relevant state or territory legislative requirements.

Service providers require policies, procedures and guidelines describing these circumstances, including who is authorised to prepare syringes, along with the documentation, storage and infection control requirements. The initiatives of **Caring@home**⁵⁰ and its extension for Aboriginal and Torres Strait Islander families, provide guidance for community healthcare service providers to develop appropriate palliative care service policies and procedures.

Where an authorised healthcare professional – for instance, a palliative care nurse prepares a syringe for an individual, their carer and/or family to use, as per the prescriber's instructions, a detailed label is to be applied to the syringe in accordance with the relevant state or territory medicines handling legislation and:

- ▶ ***National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines***⁵¹
- ▶ ***Guidelines for handling of palliative care medicines in community services***.⁵²

The label needs to include at least the following:

- ▶ Person's name and Unit Record Number (if applicable)
- ▶ Date and time of preparation
- ▶ Name of medicine and where necessary dilution fluid or diluent
- ▶ Dose of medicine (total amount of drug being delivered, for example, in mg) and, if applicable, total volume of solution (containing the dose) to be administered (mL)
- ▶ Signature of the nurse who prepared the syringe.

It is recommended that healthcare service providers use pre-printed labels to meet these requirements and to ensure legibility. Preloaded and labelled syringes may need to be stored securely and away from the reach of children – for instance, in a locked box in the refrigerator.

For healthcare professionals

When prescribing or dispensing a medicine, the relevant healthcare professional should provide clear instructions to the individual, their carer and/or family in accordance with the prescriber's intentions. This includes the information on the dispensed medicine label, as well as provision of CMI or other tailored medicines-related information.

Prescribers should talk to people about the safe and effective use of all their medicines, including prescription, non-prescription and complementary medicines, their possible adverse effects (for example, side-effects) and/or potential interactions. Information regarding possible adverse health outcomes or adverse effects, which could potentially be caused by an interaction between medicines, should be made available. For individuals on long term treatment for a chronic illness, it is also important to explain the day-to-day management of their medicines during an acute exacerbation of their illness – for instance, 'sick days'.

In addition, people taking five or more medicines are at higher risk of delirium and falls, independent of the medicines' indications. If inappropriate polypharmacy is a concern, the prescriber may need to review the person's medicines, which could result in a dose adjustment or the deprescribing of a medicine (refer to **Guiding Principle 8: Medicines list** and **Guiding Principle 9: Medication review**).

Non-prescription medicines – such as those used to treat allergies and coughs, or non-steroidal anti-inflammatory medicines for pain – may interact with prescribed medicines and have the potential to cause harm. Traditional and complementary medicines may also contribute to polypharmacy.

If there is doubt that a person is able to safely self-administer and/or store their own medicines (including medicines packed in a DAA) (refer to **Guiding Principle 11: Storage and disposal of medicines**), a healthcare professional, in consultation with those involved in the individual's care, should conduct a formal assessment – for example, Home Medicines Review (HMR), Chronic Disease Management (CDM) and/or multidisciplinary case conference, or using other locally available self-administration assessment tools.

Healthcare professionals are responsible for discussing alternative options for administering medicines (such as pump delivery systems, patches or inhalation devices) that can help an individual to self-administer their medicines or ensure that their carer or family is able to administer medicines at home.

Depending upon the device, information and education/instructions on how to use different delivery devices is required to ensure that the individual, their carer and/or family understand how to use them effectively – for instance, a syringe driver for pain management, or a spacer device for inhaling asthma medicines. An individual's technique should also be monitored periodically to ensure the device(s) is still functioning as intended, and being used effectively.

Support strategies

Attention should be paid to a person who is returning home from hospital and who might need extra support to administer their medicines during their recovery period (refer to [Guiding Principles to Achieve Continuity in Medication Management](#)).

If required, support can include provision or introduction of an appropriate DAA or other device, which can also improve a person's medicines adherence. Consent will be required from the person and/or their substitute decision maker before a DAA can be arranged and supplied by the person's community pharmacy (refer to [Guiding Principle 6: Dose administration aids](#)). Other supports or strategies could include:

- ▶ Assistance to manipulate medicine containers – for instance, loosening or removing the lid
- ▶ Electronic reminders or alarms
- ▶ Larger font on dispensed medicine labels
- ▶ Help measuring liquid medicines or administering eye drops
- ▶ Information on a person's medicines – for instance, CMI
- ▶ Engaging a care worker to assist with aspects of administering medicines (refer to [Guiding Principle 7: Administration of medicines in the community](#)).



Any strategies trialled and/or in use need to be documented in the person's healthcare record – for instance, within a general practice management system and/or patient notes within a community pharmacy dispensing system. Documentation also needs to include any potential problems the person may be experiencing with other aspects of medication management, such as whether they are storing medicines safely (refer to **Guiding Principle 11: Storage and disposal of medicines**).

Provided that it is safe, care workers (however titled) including Aboriginal Health Workers and Torres Strait Islander Health Workers, should support the individual's chosen method of self-administration and to remain independent. However, a healthcare professional has an ongoing role to provide information to the person about the management of their medicines, and care workers should refer any individual, their carer and/or family who raise questions about medicines to the individual's GP, pharmacist or nurse for advice (refer to **Guiding Principle 7: Administration of medicines in the community**).

Need for review and/or assessment

A medication management review – for instance, a Home Medicines Review (HMR) may help to identify how an individual can continue to administer their medicines safely at home and in a way that suits their needs (refer to **Guiding Principle 9: Medication review**).

The situation should be reassessed as necessary, for example, when the individual, their carer or family, or those involved in the individual's care (such as pharmacists, nurses and care workers) notice that the person's ability to manage their own medicines has lessened.

If the assessment is that the person is unable to continue administering their own medicines – for example, due to physical or cognitive impairment – a strategy for future medication management should be discussed with the individual, their carer or family, nurse, GP, pharmacist or care worker as necessary, and agreed upon by the individual.

Assessment for self-administration

If an individual needs to be formally assessed to determine their capacity to self-administer medicines safely, the assessment needs to consider:

- ▶ The person's choice and right to make their own decision
- ▶ Involvement of the individual's carer and/or family or substitute decision-maker
- ▶ If self-administration will be a risk to themselves or other people
- ▶ If they can take the correct dose of their own medicines at the right time and in the right way, for instance
 - the person's cognitive ability, including understanding of the safe and quality use of the medicines being taken
 - the person's physical ability, including dexterity, visual acuity and if they experience swallowing difficulties
 - their health literacy, including how information such as CMI and practical support such as a DAA may assist the person to self-administer their medicines
 - how the person's medicines will need to be managed during periods of acute illness or 'sick days'
 - the person's ability to comply with the safe and appropriate storage of self-administered medicines, including those that require refrigeration
- ▶ If the person has recently returned home from hospital or another care environment – for instance, respite care.

For the individual, their carer and/or family

The potential for medicines to interact increases with the number of medicines being taken. Some individuals use more than one prescriber and/or pharmacist, and should be encouraged to share information about all their medicines (prescribed, complementary and non-prescription medicines) with all their healthcare providers.

It is also important that their prescribers and pharmacists are advised of any additional medicines a person may have sourced – for instance, imported from overseas. The Therapeutic Goods Administration (TGA) provides information about [importing small amounts of medicines for personal use](#)⁵³ under the [personal importation scheme](#).⁵⁴ If the medicine is prescription-only, a valid prescription or written authority from the person's prescriber is required. However, as these imported medicines are not approved or registered in Australia, there are no guarantees about their safety or quality.

If an individual, their carer or family is unsure about the administration of any medicines, including medicines imported for personal use, they should ask their GP, pharmacist or nurse to explain the medicine's purpose, use and administration prior to administration. Referring to the medicines' CMI's may be useful in these circumstances.

Should an individual's carer or family member find that a person is having difficulty administering their own medicines, they need to encourage and/or assist the person to seek a review or assessment by their community healthcare provider – for instance, their GP. A person's carer should also consider, with the person's consent, discussing the problem with the person's care worker (however titled) who can in turn discuss this with their supervisor.

If an individual is prescribed and able to swallow a broken (or half) tablet, it is recommended that advice is sought from their GP or pharmacist regarding the medicine's suitability – for instance, it is a 'scored' tablet. It is also recommended that specialised equipment, such as a tablet or pill cutter, is used to ensure dosing accuracy. If a person becomes acutely unwell at home, they may not be able to safely manage their medicines without additional advice from their GP or pharmacist. This includes during instances of acute exacerbations of a chronic illness where changes to medicines, including withholding a medicine(s), may be required to minimise adverse drug events and/or admission to hospital. The individual, their carer and/or family

should consult their relevant healthcare professional – for instance, their GP and/or pharmacist, on how to manage these situations to ensure that if they need to take pain relief or another type of medicine it will not interact or impact any underlying chronic illness or condition.

Where an individual has been formally assessed as being able to self-administer their medicines – including prescription, complementary and non-prescription medicines – they will be supported to do so.

If required, support can include provision or introduction of an appropriate DAA or other device, which can improve a person's medicines adherence. Consent will be required to facilitate the supply of an appropriate DAA to support the person to safely administer their own medicines (refer to **Guiding Principle 6: Dose administration aids**).

Resources



A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

Reflective questions



How does the community healthcare service provider ensure that care workers (however titled) who are assisting people to self-administer their medicines in their homes are appropriately trained and competent to do this?



If a person is having difficulty in administering or managing their medicines, how is the need for a formal review or assessment managed by the individual's prescriber – for instance, their GP, or by a pharmacist – communicated and organised?

Dose administration aids

Dose administration aids (DAAs) should be used to support individuals to remain independent and reduce the risk of administration error. They should only be used when a person is assessed as having a specific problem managing or safely administering their own medicines.

Summary and intent

A person's dispensed, non-prescription and complementary medicines should remain in the original manufacturer's packaging unless using a DAA could overcome a specific problem that a person may be experiencing with managing their own medicines.

Practical aids or strategies, such as simplifying a person's dose schedule or regimen, should be considered before introducing a DAA (refer to **Guiding Principle 5: Self-administration of medicines**). The focus needs to be on the person's choice and maintaining their independence and medicine-taking skills. For instance, in those who could potentially manage their medicines from the original manufacturer's packaging with appropriately targeted information, counselling and simple adherence strategies or aids.

Assessment is a critical step to identify the type of medicines management problem a person is experiencing and whether a DAA is likely to be an effective solution. For example, a DAA may be required:

- ▶ When a person is struggling or requires assistance to manage a complex dose schedule or regimen, that cannot be simplified, and mostly consists of regularly scheduled, solid oral dose forms

- ▶ For a person who is sometimes unable to recall whether they have taken their medicines (leading to risk of double dosing) and requires a visual or audible cue – for instance, an alarm
- ▶ For a person whose medicine-taking is being monitored by their carer, family or a care worker.

DAAs may not be suitable for everyone, and their use needs to be considered carefully in a collaborative approach to a person's medication management. For instance, DAAs are not effective for addressing motivational concerns, dexterity issues and errors due to more severe cognitive impairment. Some people may find it difficult to use a DAA, for example, an individual with rheumatoid arthritis. If there is doubt that a person is able to safely self-administer and/or store medicines packed in a DAA (refer to **Guiding Principle 5: Self-administration of medicines** and **Guiding Principle 11: Storage and disposal of medicines**), a healthcare professional, in consultation with those involved in the individual's care, should conduct a formal assessment.

DAAs may be helpful in people with mild cognitive impairment, as long as they are able to:

- ▶ Understand how to use the device
- ▶ Orientate to the day and time
- ▶ Remember when, or respond to a reminder, to take their medicines.

DAA can be prepared by community pharmacists and by external (or corporate-style) providers, who provide 'remote' automated dose-packaging (for example, sachet) systems.

Irrespective of the service provider, there needs to be policies, procedures and guidelines in place for the provision of DAA services. DAA packing systems are required to meet relevant standards⁵⁵ and guidelines⁵⁶, as well as relevant state or territory legislation. In some states and territories, in exceptional circumstances and where a pharmacist is not available, another healthcare professional, such as a medical practitioner, registered nurse or Aboriginal Health Worker, may be authorised to prepare a DAA.

The cost of DAAs can be restrictive for some patients, depending on a person's eligibility for subsidies and rates charged by community pharmacies.

Key terms

All technical terms in these Guiding Principles are defined in the ***Glossary for the Guiding Principles and User Guide***. This section provides background, contextual and additional information on the use of key terms in the specific context of this Guiding Principle.

Dose administration aids (DAAs)

DAAs are devices or packaging systems such as blister packs, bubble packs or sachets, compartmentalised boxes, or compliance packs such as those provided by automated dose-packaging systems. DAAs are widely used in the community and are designed to assist people to self-administer their medicines. They are used to improve efficiency and support safe and accurate administration of medicines by organising the medicines according to the dose schedule and time they are to be taken, or administered, throughout the day.

A DAA is prepared according to the personalised needs of the individual, and is likely to differ from person to person. Any DAA or DAA packing system that is selected by an individual and utilised by the pharmacy that dispenses the person's medicines is required to meet expected standards⁵⁵ and guidelines.⁵⁶

The most suitable DAA for a person self-administering is likely to be a multi-dose pack (different types of medicines contained within each blister or sachet or compartment).

Potential issues

DAAs offer several 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 self-administered. They might be difficult to label with medicine information or cautionary advisory labels (CALs) unless specifically designed

Changes in medicines may occur due to prescriber review, changes in a person's health status, including periods of acute illness, and at transitions of care – for instance, hospital discharge. Whilst not intentional, the following are examples of packing errors that can occur:

- ▶ Inclusion of a medicine in the DAA which had been ceased
- ▶ Wrong dose of a medicine was packed
- ▶ Packing a medicine in the DAA at an incorrect administration time
- ▶ Omission of medicines that should have been packed.

Medicines in DAAs may include prescription, complementary and non-prescription medicines. However, only solid oral dose forms of medicines intended for routine use can be packaged in this way. Some solid oral dose forms of medicines with particular storage, stability or handling requirements, are not suitable for use in DAAs or may need to be packaged or secured in a specific manner. For instance:

- ▶ PRN (*pro re nata*) medicines should be packed separately
- ▶ Cytotoxic medicines should be packed separately with appropriate cautionary labels
- ▶ Temperature-sensitive medicines may need to be packed separately and stored in the fridge
- ▶ Schedule 8 medicines should be packed separately and securely stored in accordance with the relevant state or territory legislative requirements.



Communication requirements

Timely and accurate communication is needed between prescribers (for instance, medical or nurse practitioners), pharmacists, nurses and community healthcare service providers about medicines ordered in DAAs. The time between ordering, preparation and delivery can affect continuity of medicines supply. Matters to be considered include:

- ▶ The type of DAA – for instance, blister pack, sachet, compartmentalised box or compliance pack
- ▶ How to communicate to the supply pharmacist all medicine orders or changes, including whether these require ‘immediate’ or ‘next-pack’ changes
- ▶ How continuity of access to medicines supply will be maintained when medicine orders change
- ▶ Ensuring documented procedures are in place (with the contracted supplier)
 - to manage delays that may arise in response to changes to medicines within the DAA when supplied with ‘remote’ automated dose-packaging – for example, sachets
 - which include medication reconciliation, to minimise the potential for packing errors, if a local pharmacy is used to provide the DAA
 - for the labelling of DAAs where special instructions are required – for instance, additional DAAs or medicine containers, DAA commencement date or information such as ‘do not crush or chew’ a medicine.

Implementation – key tasks and strategies

For the providers of community healthcare services

The healthcare service provider needs to have organisational medication management policies, procedures and guidelines in place.

Role of the care worker (however titled)

A care worker should only physically assist a person in using their DAA if the person is responsible for their own medication management, and where agreement has been reached between the person and service provider in accordance with relevant Australian, state or territory legislation. For additional information on the role of a care worker in the administration of medicines (refer to **Guiding Principle 7: Administration of medicines in the community**).

Depending upon the amount of assistance required, the care worker might need to prompt a person to remove and take the medicine. If assistance includes removing medicines from a DAA, care workers need to have competency-based training in accordance with a service provider’s organisational policies, procedures and guidelines and Australian, state or territory legislation.

In the event of an urgent dosage or medicine change where an individual is self-administering medicines from a DAA, the DAA should be returned immediately to the pharmacy or Aboriginal Medical Service for re-packing and re-delivery. The registered nurse, care worker or community healthcare service provider needs to liaise with the individual about returning the DAA to the pharmacy and arrange alternate supply where necessary.

All community healthcare service providers and care workers (however titled) need to report any concerns about a person's ability to manage their medicines, whether using a DAA or not, to the person's prescriber – for instance, their GP, and/or pharmacist.

For healthcare professionals

Ideally, before introducing a DAA, review and simplification of a person's dose schedule or medicines regimen should be considered (refer to **Guiding Principle 9: Medication review**). Opportunities include:

- ▶ Medication review by the person's prescriber (for example, their GP)
- ▶ During the DAA assessment process by the GP or pharmacist
- ▶ Medication review by a pharmacist – for instance, HMR.

Prescribers and pharmacists will need to consider and discuss alternatives for medicines that are not suitable to pack in a DAA (see **Table 1**).

If a person wants to have their non-prescription and complementary medicines included in their DAA, the pharmacist needs to check for potential interactions and other considerations, and with the individual's consent, inform the prescriber.

With the consent of the individual, their carer and/or family it is the responsibility of the prescriber to notify the pharmacist, the individual's carer, other healthcare professionals and/or community healthcare service provider and care worker of any changes, and the individual's medicines list updated accordingly (refer to **Guiding Principle 8: Medicines list**).

Assessment

Assessments to identify individuals who may potentially benefit from the use of DAAs can be conducted by a healthcare professional, such as the individual's GP or pharmacist upon the request of an individual or their carer, or another healthcare professional.

A guide on identifying individuals likely to benefit from a DAA is provided opposite in **Box 1**. Although there is no single set of criteria that can be applied, a DAA is likely to be more effective where a person:

- ▶ Is motivated and willing to take their medicines, their medicines' dose schedule or regimen is reasonably stable
- ▶ Has cognitive capacity, including understanding of how to use the DAA and safe and quality use of the medicines taken
- ▶ Has physical ability, including dexterity and visual acuity.

A person's rights must be considered, including making an informed decision to use a DAA as well as choosing the most suitable device. If a person is not eligible for a subsidised DAA service, any costs associated with packaging a person's medicines in a DAA also need to be explained to them.

People who are using DAAs should be monitored and, if necessary, reassessed to make sure that they continue to administer their medicines safely (refer to **Guiding Principle 5: Self-administration of medicines**).

Preparation

DAAs are to be packed and fully labelled either by a pharmacist or under the supervision of a pharmacist, in accordance with the *Guidelines for pharmacists providing dose administration aid services*⁵⁵, *professional practice standards*⁵⁷ and Pharmacy Board of Australia *guidelines*⁵⁶. The DAA should also contain features that will show if the container has been tampered with before any medicines have been administered, and depending on the individual requirements of the person receiving the medicines. For instance, if a care worker is to assist a person to use their DAA and it is evident that the DAA has been tampered with, it must be returned to the pharmacist for repacking.

Box 1: Individuals likely to benefit from a DAA

Individuals:

- ▶ With a medical history suggesting they have problems managing their medicines (for example, prior hospitalisation due to adherence issues)
- ▶ Who have difficulty remembering if they have taken their medicines, and who would benefit from a visual or audible cue
- ▶ Who have a carer or family member who monitors their medicine taking
- ▶ With a complex regimen of medicines with a regular dosing schedule of solid oral dose forms suitable for packing in a DAA (refer **Table 1** for those not suitable for packing in a DAA)
- ▶ With signs of physical or cognitive limitations which may affect their ability to effectively manage medicines (there needs to be an adequate level of cognition to manage a DAA)
- ▶ Taking five or more medicines daily (including complementary and non-prescription medicines).

Adapted from the PSA *Guidelines for pharmacists providing dose administration aid services*.⁵⁵

All or part of a person's medicines regimen might be provided in a DAA. Medicines should remain in their original container or packaged separately in unit dose packs in cases where either of the following occurs:

- ▶ Medicines are ordered as a short-course treatment
- ▶ The regimen is complicated
- ▶ There are specific requirements regarding timing of administration in relation to meals and other medicines
- ▶ The medicine has special storage requirements – for instance, requires refrigeration to maintain its integrity.

Prompts should be included on DAA labels that other medicines are to be taken or administered.

Community pharmacists may engage a third-party provider to pack DAAs via a written agreement. Whilst the packing pharmacist at the third-party provider is responsible for ensuring the DAA is packed accurately in a timely manner, the community pharmacist is ultimately responsible for the DAA service and the suitability for medicines to be packed in DAAs.

Pharmacists must use their professional judgement to determine which medicines to pack in an individual's DAA. The pharmacy's DAA service policies, procedures and guidelines need to include a list of medicines that should not be packed, and any special storage conditions. Examples of medicines that may not be suitable are shown in **Table 1**.

In some states and territories, a healthcare professional or care worker other than a pharmacist – that is, a registered nurse or Aboriginal Health Worker or Torres Strait Islander Health Worker – might fill a DAA. Nurses, Aboriginal Health Workers and Torres Strait Islander Health Workers need to refer to relevant legislation, guidelines and service provider policies for when this may occur. Before packing a DAA, they need to liaise with the person's prescriber and dispensing pharmacist to ensure all relevant information is obtained and recorded in the activity document in the individual's clinical notes (paper-based or electronic).

Changes in medicines may occur due to prescriber review; changes in a person's health status, including periods of acute illness (or 'sick days'), and at transitions of care, for instance, hospital discharge.

To minimise packing errors or problems, and especially when changes are made to a person's DAA, their contents need to be reconciled against the person's most recent prescription and/or medication profile by the pharmacist (or other healthcare professional) responsible for preparing or checking the DAA. This needs to be completed in a timely manner, especially for those receiving a DAA for the first time and to ensure continuity of medicines supply.

Table 1: Examples of medicines that may not be suitable for packing in a DAA

Note: This list is not exhaustive and has been adapted from the PSA *Guidelines for pharmacists providing dose administration aid services*.⁵⁵

| Type of tablet | Examples |
|---|--|
| Buccal tablets | Amphotericin B (amphotericin) lozenges |
| Chewable tablets | Vitamin C |
| Dispersible tablets | Piroxicam dispersible tablets |
| Effervescent tablets | <ul style="list-style-type: none"> ▶ Effervescent forms of potassium chloride ▶ Soluble aspirin tablets |
| Hygroscopic tablets | Sodium valproate |
| Moisture-sensitive medicines | Wafer presentations (for example, olanzapine) |
| Sublingual tablets | <ul style="list-style-type: none"> ▶ Glyceryl trinitrate sublingual tablets ▶ Buprenorphine hydrochloride sublingual tablets |
| Tablets containing aluminium hydroxide and/or magnesium or other salts | <ul style="list-style-type: none"> ▶ <i>Gaviscon</i> tablets ▶ Hexamine Hippurate (methenamine hippurate) tablets ▶ Omeprazole (and omeprazole magnesium) tablets (unless packed monthly) |
| Tablets exceedingly sensitive to light degradation | <ul style="list-style-type: none"> ▶ Nifedipine ▶ Tamoxifen |
| Other medicines where limited time in a DAA may be appropriate | Thyroxine sodium (levothyroxine sodium) |
| Other medicines where there are specific contraindications for repacking (or removing from the original packaging) according to the manufacturer's instructions | Dabigatran (Pradaxa) |



A DAA reconciliation also needs to be conducted at the time a medication management review such as a Home Medicines Review (HMR) or MedsCheck is completed, including assessing or reassessing the continuing requirement for use of a DAA (refer to **Guiding Principle 9: Medication review**).

There are safety limitations to the use of DAAs. For example, they might be difficult to label with all the required medicines information or CALs. A separate document may be useful for any additional medicines-related information that is not mandated and does not fit on the DAA. People need to be able to easily read, identify and determine which label applies to which medicine.

Procedures

Communication procedures need to be set up between all involved in the person's care. This can include the individual's prescriber(s), pharmacist, nurses, care worker and their carer, family or substitute decision-maker.

The pharmacist needs to verify an individual's medicine orders, including changes to the contents of a DAA, with the prescriber where necessary.

The pharmacist needs to keep a master copy of each person's medication profile (paper-based or electronic) and should only make changes according to written or direct communication from the individual's prescriber. These communications need to be recorded according to professional guidelines.

Pharmacists should use their professional judgement to determine the best way to implement changes to an individual's DAA, including the urgency and the number of DAA packs that are affected.

Timely and accurate communication about DAA availability is also needed as the time between ordering, preparation and delivery can affect continuity of a person's medicines supply. Matters to be considered include:

- ▶ How to communicate whether DAAs require 'immediate' or 'next-pack' changes
- ▶ How continuity of access to medicines supply will be maintained when medicine orders change
- ▶ Ensuring documented procedures are in place (with the contracted supplier)
 - to manage delays arising in response to changes to medicines within the DAA when supplied by 'remote' automated dose-packaging – for example, sachets
 - for the labelling of DAAs where special instructions are required – for instance, additional DAAs or medicine containers, DAA commencement date or information such as 'do not crush or chew' a medicine
 - managing traceability of the medicines packed in DAAs, especially in the event of a recall.

Quality assurance activities also need to be implemented to make sure the DAA service is audited regularly – for instance, using the Standard 15: Dose Administration Aid Service from the **Professional Practice Standards**⁵⁷ as a tool for self-assessment.

Administration by nurses

It is preferred that a registered nurse administer medicine from the container in which the medicine was originally dispensed. However, if a person has been supplied with a DAA (which has not been packed by a registered nurse), a registered nurse should only administer these medicines if they have a document or medication chart completed by the prescriber and the medicines can be clearly identified.



The **ANMF Position statement on the Use of dose administration aids**⁵⁹, outlines that nurses who administer medicines from DAAs are expected to take responsibility for identifying each individual medicine prior to administration. If unable to identify any medicines, nurses must consult the pharmacist and return the DAA to them for repackaging. The use of a unit-dose pack (where only one medicine is contained in each column of blisters, or sachets) will assist with medicine identification and may facilitate safe and accurate administration (refer to **Guiding Principle 7: Administration of medicines in the community**).

For the individual, their carer and/or family

Where DAAs are assessed to be appropriate for a person, information should be provided and discussed around the initiation and continuing use of DAAs, and the individual's consent obtained.

Some medicines may not be suitable for packaging in a DAA – for instance, medicines requiring refrigeration. This will need to be explained to the individual, their carer and/or family so that they know to take additional medicines that have been retained in their original packaging and/or stored separately.

People may choose for some of their medicines to remain in their original packaging rather than packed in a DAA. This may necessitate a risk assessment of the individual's ability to self-administer and, if relevant, support to self-administer the medicines that are not packed in a DAA (refer to **Guiding Principle 5: Self-administration of medicines**).

A person may want to have their non-prescription and complementary medicines included in their DAA. However, the pharmacist should inform the prescriber when they have identified potential interactions and/or other considerations that may cause a potential adverse health outcome for the individual. Ideally, this should be discussed with the individual and their consent obtained.

The DAA needs to be returned to the pharmacist for repackaging if there are any changes to the person's medicines. The person's medicines list will need to be updated and if necessary, with assistance from their carer and/or family, the pharmacist, or other healthcare professional (refer to **Guiding Principle 8: Medicines list**).

As the medicines packaged in a DAA have been removed from their original packaging, they should be stored away from heat, light and moisture. The guidance provided within **Guiding Principle 11: Storage and disposal of medicines** is applicable to medicines packaged in DAAs.

Resources



A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

Reflective questions

-  **What assessment and consent processes are in place to determine the suitability for a person to be supplied their medicines packed in a dose administration aid (DAA)?**
-  **How does the community healthcare service provider ensure that only those medicines that are suitable are packed in a DAA?**
-  **What process does the community healthcare service provider or healthcare professional follow to ensure that the contents of a DAA are reconciled, and that risks with their use are minimised, especially when changes are made to a person's DAA?**

Administration of medicines in the community

People who live at home have access to and receive suitable information and/or assistance so that they can take their medicines safely and effectively. Healthcare professionals, care workers and healthcare service providers all play an important role.

Summary and intent

Communication, collaboration and coordination between healthcare service providers, healthcare professionals and care workers (however titled) who are providing care for people living in the community are essential elements for safe and effective medicines administration (refer to **Guiding Principle 2: Communicating about medicines**). This becomes particularly important when a person is unable to take responsibility for their own medicines and/or their carer or family needs help in managing and/or administering the person's medicines.

Many people may have a family member or other person involved in their day-to-day care. Depending upon the circumstances, an individual's carer and/or family should be directly involved in the administration of medicines and/or their management – for example, in the care of children.

For most people living at home with functional disabilities arising from frailty or other causes, their medical practitioner – for instance, their GP – is their coordinator of care and main provider of healthcare services. Where an individual is unable to manage and self-administer their own medicines due to physical or cognitive limitations, decisions need to be made about the most suitable person to assist them – for instance, a family member. If necessary, another form of assistance may be required.

State and territory legislation varies in the extent to which it regulates the administration of medicines once prescribed, dispensed and supplied for or to an individual. However, legislation regulating professional groups – for instance, the *Health Practitioner Regulation National Law Act 2009*⁶, and guidelines for government funded programs – may set out rules controlling the circumstances in which different groups of healthcare professionals and other care workers (however titled) may administer medicines. Examples include pharmacotherapy supervised dosing programs and use of disability support workers.

Other instances where medicines are administered by healthcare professionals include:

- ▶ Influenza vaccinations by nurse immunisers, GPs or pharmacists
- ▶ Administration of monthly depot formulations of medicines in general practice or a mental health clinic
- ▶ Palliative care medicines
- ▶ Cancer chemotherapy.

Key terms

All technical terms in these Guiding Principles are defined in the *Glossary for the Guiding Principles and User Guide*. This section provides background, contextual and additional information on the use of key terms in the specific context of this Guiding Principle.

Self-administration of medicines

'Self-administration' is when a person can take their own medicines (refer to **Guiding Principle 5: Self-administration of medicines**).

Acute illness or 'sick days'

The risk of adverse events may increase during periods of acute illness due to comorbidities or medicine use (for example, gastroenteritis or diarrhoea)⁴⁹ or for acute exacerbations of a person's chronic illness – 'sick days'.

Some medicines may need to be temporarily suspended – for instance, diuretics, or the dose temporarily increased – for example, insulin. Factors to consider will include the type of medicine, its formulation pharmacokinetics, duration of the acute illness and comorbidities.

Administration of medicines

Administration practices must be in accordance with legislation, professional and regulatory requirements, and the community healthcare service provider's medicines administration policies, procedures and guidelines.

The primary focus of medicines administration practice is on ensuring quality outcomes for people through the safe and accurate 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, and that the administration is documented – for instance, on the individual's medication chart (paper-based or electronic).

In the context of psychotropic medicines, consent provided at each instance of administration should also be documented.

Monitoring the outcomes of medicines administered to individuals and having effective processes for recording medicines-related problems, are especially important given the correlations between increased age, use of multiple medicines (polypharmacy), adverse reactions, medication errors and medication incidents.

Where a healthcare professional, such as a registered nurse is involved, no medicine is to be administered unless it has been ordered by a prescriber and dispensed by a pharmacist into an individual container or pack, which is labelled with the:

- Person's name
- Name and strength of the medicine
- Dosage, frequency and route of administration.

Exceptions include:

- Pharmacist initiation of medicines
- Nurse-initiated medicines
- Administration by a nurse from a medication treatment protocol and in accordance with legislative requirements and community healthcare service provider policy.

Refer to **Guiding Principle 8: Medicines list** and **Guiding Principle 12: Authorised initiation of medicines in the community**.

Implementation – key tasks and strategies

For the providers of community healthcare services

Community healthcare service providers need to take all relevant legislation into account in determining their own policies, procedures and guidelines, as well as in providing training to care workers (however titled) on the administration of medicines to people living in the community. This includes:

- Recording/documenting the administration of medicines – for example, on a medication chart (paper-based or electronic)
- Identifying those circumstances where care workers are not authorised to administer medicines.

Community healthcare service providers need to ensure access to an up-to-date list of a person's medicines – for instance, within the person's healthcare service record or file (paper-based or electronic).

Community healthcare service providers need to be aware of their employees' levels of skill and knowledge and provide the necessary training to ensure each person's duty of care is met.

They should not expect or require employees to perform tasks beyond their knowledge, skills, experience and training.

For instance, care workers (however titled) in some states or territories can help people who are responsible for managing their own medicines, by providing assistance with opening a medicine container – for instance, unscrewing bottle lids or removing medicines from a container and place them in the person’s hand.

Role of care workers (however titled)

People other than registered nurses or enrolled nurses, such as enrolled nurses not authorised to administer medicines, or assistants in nursing/ personal care workers (however titled), may only assist or support a person to self-administer their own medicines (refer to **Guiding Principle 5: Self-administration of medicines**).

Community healthcare service providers should ensure that care workers have completed a suitable competency/vocational training course via a **registered training organisation (RTO)**⁶⁰, registered by the **Australian Skills Quality Authority (ASQA)**.⁶¹ For instance, Certificate III in Individual Support, or its equivalent, includes a unit of competency that prepares community care workers to physically assist people with their medicines.

Given that these vocational courses may require a placement within a residential care facility, some community healthcare service providers deliver provider-specific competency-based training for their care workers who assist people in their homes with medication management.

All care workers need to be guided by their community healthcare service provider’s policies, procedures and guidelines for the administration of medicines. In addition, within each person’s care or management plan there need to be clear instructions about what steps the care worker will take to support an individual, their carer and/or family member in the administration of medicines. The required level of support will depend on the individual and their healthcare needs and preferences.

Care workers are not authorised to make any decisions about whether a medicine should be administered and need to seek assistance from their supervisor if they have any concerns about a person’s management of their medicines.

Where a person runs out of their current supply of medicines, care workers need to seek the advice and/or assistance of the individual’s primary healthcare provider (for instance, their GP), or their pharmacist, registered nurse, or the usual source of supply – for example, Aboriginal Medical Service (AMS), as dictated by the individual’s circumstances.

Most states and territories have legislation that provides for some care workers to administer medicines. For example, Tasmania’s **Disability Services Management Framework**⁶² outlines the requirements for disability service providers and disability support workers. A trained and competent care worker can help when an individual or their carer and/or family require physical assistance to administer the individual’s medicines (refer to **Guiding Principle 6: Dose administration aids** for additional information).

Administration of medicines by Aboriginal Health Workers

Aboriginal Health Workers play a unique and pivotal role in the healthcare of Aboriginal people in the community. They are recognised as an integral part of the primary healthcare provider team.

Some states and territories have legislative provisions in place for Aboriginal Health Workers to administer some medicines such as vaccines and antibiotics. To be able to administer medicines, Aboriginal Health Workers must have relevant qualifications. For instance, Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice, or its equivalent, includes core units of competency that prepare Aboriginal Health Workers to administer medicines and support people with the safe use of medicines. They must also be authorised to do so according to relevant state and territory legislative requirements and healthcare service provider policies, procedures and guidelines.



For healthcare professionals

Administration of medicines by nurses

A registered nurse is the most appropriate person to manage the medicines dose schedule or regimen for a person receiving aged care services. Registered nurses are trained and qualified to:

- ▶ Understand the therapeutic action of medicines, including
 - the reason for their use
 - the effects of their use
- ▶ Recognise adverse reactions and respond appropriately.

Registered nurses must use clinical judgement to assess whether medicines should be administered or withheld with regard to the consumer's health and family history, diagnosis, co-morbidities and health status. This includes the management of medicines during periods of acute illness (or 'sick days').

Registered and enrolled nurses are professionally regulated through the Nurses and Midwives Board of Australia (NMBA) and are accountable to professional standards. The 2013 Australian Nursing and Midwifery Federation (ANMF) *Nursing Guidelines: Management of Medicines in Aged Care*⁶³ provides support and direction for registered and enrolled nurses in the administration of medicines to those receiving aged care services.

If registered and enrolled nurses are administering medicines from a DAA, it must be packaged and fully labelled by a pharmacist. Registered and enrolled nurses must not administer from DAAs where individual medicines cannot be clearly identified.

If a dose is not taken for any reason other than predetermined or prescribed reasons, such as an informed decision not to take a medicine, the registered nurse must consult the individual's prescriber. Registered nurses also have a role in educating an individual's carer about the safe and appropriate administration of medicines.

In addition, registered nurses need to follow relevant professional practice standards when administering medication to ensure that the right medicine is administered to the right person in the right dose at the right time via the right route. All instances of administration of a medicine need to be documented on a medication chart (paper-based or electronic).

Registered and authorised enrolled nurses can administer medicines only when an authorised prescriber has prescribed the medicine. Australian, state and territory legislation, together with organisational policies, define some medicines as potential 'nurse-initiated medicines'. These medicines can be administered by a registered nurse without authorisation by an authorised prescriber.

They include some Schedule 2 and 3 medicines (refer to **Guiding Principle 12: Authorised initiation of medicines in the community**).

For the individual, their carer and/or family

People need to be supported to have an active role and make choices and decisions about their care, including the medicines they take or are administered. This includes being provided information about:

- ▶ Medicines administration and self-administration policies, procedures and guidelines
- ▶ Assessment of the person's capacity and ability to self-administer their medicines, including the appropriate storage of medicines (refer to **Guiding Principle 5: Self-administration of medicines**)
- ▶ Managing their medicines if they become acutely unwell at home – for instance, for acute exacerbations of a person's chronic illness – 'sick days'
- ▶ The assessment and consent process for use of DAAs (refer to **Guiding Principle 6: Dose administration aids**)
- ▶ The assessment for the safe swallowing of medicines before being administered, and the referral process for people suffering swallowing difficulties
- ▶ Which oral dose forms of medicines can and cannot be altered – such as by crushing or chewing – along with any special conditions relating to the alteration or administration of specific medicines (refer to **Guiding Principle 10: Alteration of solid oral dose forms**).

Many people remain independent and can manage their medicines without assistance of any kind. However, as people get older they may have a family member or other person involved in their day-to-day care, including assistance with the administration of their medicines.

People who cannot manage alone and/or have specific needs, including those with a disability, need to be individually supported in a safe, respectful and appropriate manner. They also need to be supported to navigate any assessment and consent processes involved in the use of medicines.

Resources



A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

Reflective questions



What policies, procedures and guidelines are in place to support:

- ▶ **Documentation of administration (and self-administration) within a person's health record?**
- ▶ **The assessment of a person's capacity to self-administer their own medicines?**
- ▶ **The referral process for a person with swallowing difficulties?**
- ▶ **The consent process for a person to use a DAA?**



How does the community healthcare service provider ensure that a person's medicines administration records are accurate, kept up-to-date and remain secure, and are only viewable by those with permission to view?

Medicines list

Everyone taking one or more medicines should be encouraged and supported to maintain an up-to-date list of all their medicines. This list should be available and easily accessible to the individual and all those involved in their care.

Summary and intent

Everyone taking medicines is encouraged to keep a list of all their current medicines, including prescription, non-prescription and complementary medicines. Information and tools are available for people on how to keep an up-to-date **medicines list**.⁶⁴ People are also encouraged to update their own medicines' records within their **My Health Record**.⁶⁵

The more medicines a person takes, the more difficult it can be to remember everything involved. Keeping a person's medicines list up to date will ensure that everyone involved in the person's healthcare knows which medicines are being used, how often they are being used, and why.

The person's carer, family, healthcare professionals and care workers should actively encourage keeping an up-to-date medicines list, regardless of whether medicines are being self-administered or administered with assistance. A person, their carer and/or family need to take responsibility for updating their own medicines list, with assistance from a healthcare professional, if required.

Medicines lists need to be person-centred and tailored to their specific needs. Engaging visuals – such as pictures of tablets, sun for daytime and moon for evening medications – should be considered for those with limited health literacy or who use English as a second language. This might also include offering individuals and their carers and/or families – for instance, Aboriginal and Torres Strait Islander peoples or from culturally and linguistically diverse backgrounds, access to interpreters, and where possible, supplemented with translated resources (refer to **Guiding Principle 2: Communicating about medicines**).

People may prefer a list that has been generated by their prescriber or pharmacist, such as a 'patient medication profile' or **MediList**.⁶⁵

People need to inform their prescribers, pharmacists and nurses about all the medicines they are taking so that:

- ▶ An accurate history of an individual's medicines is documented
- ▶ Errors are not made when medicines are prescribed, dispensed and/or administered.

The prescriber and pharmacist need to ensure an individual's own medicines-related records such as the **My Health Record**⁶⁵ and/or **medicines list**⁶⁴ are also updated.

Key terms

All technical terms in these Guiding Principles are defined in the ***Glossary for the Guiding Principles and User Guide***. This section provides background, contextual and additional information on the use of key terms in the specific context of this Guiding Principle.

Medicines list

At a minimum, the medicines list should include:

- ▶ The person's complete name, address and date of birth
- ▶ The name and contact details of the individual's doctor or prescriber and community pharmacy
- ▶ Details of all medicines the person is currently taking, by including active ingredient (and brand), strength and form, dose, frequency, route, duration and indication
- ▶ Any allergies and previous adverse drug reactions that the person has experienced
- ▶ Details of any vaccinations the person has received.

Implementation – key tasks and strategies

For the providers of community healthcare services

Community healthcare service providers need to have policies, procedures and guidelines that cover situations where a person's medicines list may have changed as a result of:

- ▶ Being prescribed new medicines or dose alterations
- ▶ After returning home from hospital, an outpatient appointment or respite care
- ▶ When temporary medicine administration changes are required – such as during episodes of acute illness or 'sick days'.

If a person has any changes to the previous medicines regimen, the community healthcare service provider may need to liaise with the individual's prescriber and/or community pharmacist for further instructions before medicines are administered by the individual or the healthcare professional, care worker or person's carer (further information is available in the ***Guiding Principles to Achieve Continuity in Medication Management***). Care workers may also need to ensure the individual understands these changes before providing assistance.

For healthcare professionals

The healthcare professional – for instance, the individual's GP, pharmacist or nurse – should confirm with an individual that they understand any changes to their medicines regimen (including brand substitution) and the need to update their medicines list accordingly.

The healthcare professional should also ensure that a person's medicines list indicates whether they are receiving assistance with the administration of any of their medicines (refer to **Guiding Principle 7: Administration of medicines in the community**).

Informed consent must be obtained from a person to share information on their medicines list with others involved in their care – for example, healthcare professionals and community healthcare providers. It is recommended that the consent be obtained in writing, signed, dated and witnessed, and include the following information about the individual:

- ▶ Full name
- ▶ Date of birth
- ▶ What the individual is consenting to – for example, sharing of information on the individual's medicines list with a named community healthcare service provider.

A copy of the signed consent needs to be given to the individual, their carer and/or family.

If a medication review – for instance, Home Medicines Review (HMR), is conducted and the prescriber makes changes to the individual's medicines regimen, it is important that their medicines list is updated accordingly and that the person's dispensing pharmacist is advised (refer to **Guiding Principle 9: Medication review**).

Reconciliation of a person's medicines may involve the pharmacist consulting or collaborating with the individual's prescriber to confirm the **medicines list**⁶⁴ is correct. Medication reconciliation needs to occur:

- ▶ Prior to packing a dose administration aid (DAA) for the first time
- ▶ After changes to medicines – for instance, dose or regimen change
- ▶ After returning home from hospital, an outpatient appointment or respite care
- ▶ When temporary medicine administration changes are required – such as during episodes of acute illness or 'sick days'.

Regular medication reconciliation needs to occur, so as to also ensure that the individual's list of medicines for packing in the DAA remains up to date and accurate (refer to **Guiding Principle 6: Dose administration aids**).

For the individual, their carer and/or family

People need to be encouraged to hold and maintain a current record of their medicines (paper-based or electronic), which has been verified by their prescriber and/or pharmacist – such as a 'patient medication profile', MediList, **medicines list**⁶⁴ or **Pharmacist Shared Medicines List**⁶⁷ held within the person's My Health Record.

People need to inform their primary healthcare provider (for instance, their GP), pharmacist, registered nurse, and/or Aboriginal Health Worker of all the medicines they are taking, including medicines that they have imported for their personal use or obtained without a prescription – for instance, complementary and non-prescription medicines. People also need to advise of any changes to their medicines, or new medicines commenced by other healthcare professionals – for instance, a medical specialist.

If possible, an electronic version of an individual's medicines list should be accessible at all times by the individual's carer, community healthcare service provider or nurse responsible for administering or assisting with the administration of an individual's medicines.

Alternatively, a paper-copy of their medicines list should be kept with the person's medicines. A person's carer and/or family can play a role in confirming that they understand their medicines, especially when changes occur – for instance, a dose alteration or new brand of a medicine.

In the event of an emergency, a person's medicines list needs to be available to all involved in the person's healthcare so that it can be easily produced for reference by other healthcare professionals or healthcare service providers – for example, when transferring care to a hospital (refer to **Guiding Principles to Achieve Continuity in Medication Management**).

Resources



A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

Reflective questions



How do community healthcare service providers assist or encourage people to update their medicines list which may have changed as a result of:

- ▶ Being prescribed new dose alterations or ceased medicines?
- ▶ After returning home from hospital, an outpatient appointment or respite care?
- ▶ When temporary medicine administration changes are required – such as during episodes of acute illness?



How do community healthcare service providers ensure that the use of complementary and non-prescription medicines is recorded in the person's My Health Record and/or personal medicines list?

Medication review

A person has the right for their medicines to be routinely and regularly reviewed with members of their healthcare team. These reviews should be conducted in accordance with relevant professional responsibilities, practice standards and guidelines.

Summary and intent

Regular medication review is important to ensure that a person's medicines are being used safely, for the intended purpose and to achieve the best possible experience and outcome.

Depending upon a person's circumstances, medication review may need to be performed remotely, for instance, via telehealth.

It is particularly important where there has been a significant change in a person's health status or medicines use. This includes behavioural changes or cognitive decline for which psychotropic medicines may be prescribed. Regular medication review is recognised as best practice in medical practitioner and pharmacist professional practice standards and guidelines.

Medication reviews aim to identify, resolve and prevent medicines-related problems. They also aim to optimise medicines use in partnership with the person and their carer (refer to **Guiding Principle 1: Person-centred care**).

Medication review is intended to be collaborative and involve the individual's medical practitioner, pharmacist and other relevant healthcare service providers, for instance, community or palliative care nurses, Aboriginal Health Workers and Torres Strait Islander Health Workers and other care workers (however titled).

Whilst a comprehensive medication review by a pharmacist is ideal – for example, a Home Medicines Review (HMR) – medicines should also be reviewed by the relevant healthcare professional whenever decisions are being made about prescribing, dispensing and administering medicines.

There may be situations where healthcare professionals, other than pharmacists, need to consider and review the appropriateness of a medicine, the suitability of its formulation, or a change in a person's situation or condition that prompts an 'ad hoc' review of their medicines. It is possible that this would prompt referral to their primary healthcare practitioner or contact with the individual's pharmacist for advice and/or review.

Each healthcare professional involved in a person's care has the responsibility to use their specific knowledge, skills and expertise to ensure the safe and quality use of medicines by all people in their care. If risks with medicines use are identified early, it may prevent harm and/or unnecessary escalation in care such as calling an ambulance, an emergency department attendance or hospital admission.

In conducting a medication review, comprehensive information about the person's use of medicines (including prescription, self-selected complementary and non-prescription medicines) is collated and assessed to identify and meet medicines-related needs. It also helps to identify, resolve and prevent medicines-related problems, including inappropriate polypharmacy. If there is no clear benefit, or if

continued use of a medicine may cause harm, this may result in a recommendation to cease (or deprescribe) one or more medicines. A person's medicines regimen can be simplified through the use of structured tools⁶⁸ and strategies.⁶⁹

The Royal Australian College of General Practitioners (RACGP) *RACGP aged care clinical guide (Silver Book)*, Part A, Medication management⁷⁰ contains a series of 'consensus-based recommendations' for GPs, including the need for medication review and deprescribing. The RACGP Silver Book also contains chapters on managing older people with **polypharmacy**⁷¹ and **deprescribing**.⁷²

Given the close relationship within the scope of medication management, Guiding Principle 9 should be read in conjunction with **Guiding Principle 8: Medicines list**.

Effective and collaborative communication is also essential to facilitate a person's involvement in shared decision-making and to ensure safe and quality use of medicines (refer to **Guiding Principle 2: Communicating about medicines**).

Key terms

All technical terms in these Guiding Principles are defined in the *Glossary for the Guiding Principles and User Guide*. This section provides background, contextual and additional information on the use of key terms in the specific context of this Guiding Principle.

Polypharmacy

'Polypharmacy' is the use of multiple medicines to prevent or treat medical conditions. It is commonly defined as the concurrent use of five or more medicines by the same person.⁷³ Medicines include prescription, complementary and non-prescription (or OTC) medicines.

Older people taking five or more medicines are at higher risk of delirium and falls, independent of the medicines' indications.⁷³ Apart from prescribed medicines, a person can be taking non-prescription (or OTC medicines) – such as those used to treat allergies and coughs, or non-steroidal anti-inflammatory medicines for pain – which may interact with prescribed medicines and have the potential to cause harm. Traditional and complementary medicines may also contribute to polypharmacy.



Deprescribing

Deprescribing is defined as the thoughtful and planned process of stopping or reducing the dose of inappropriate medicines that⁷²:

- ▶ Have no clear benefit
- ▶ May cause harm
- ▶ Are being used for an indication that is no longer required
- ▶ No longer fit with the current goals of care.

This involves following a series of steps including:

- ▶ Assessing the person to establish goals of care
- ▶ Obtaining a comprehensive medication history
- ▶ Identifying medicine(s) that may be appropriate to stop or reduce
- ▶ Prioritising medicine(s) that should be stopped or reduced first
- ▶ Developing a plan for stopping or reducing the medicines
- ▶ Monitoring and documenting outcomes after each medicine has been stopped or reduced.^{71,72}

The plan for deprescribing varies according to each medicine class. It may involve abrupt cessation, a tapering approach, and/or switching to another medicine.

The overall goal of deprescribing should be to improve a person's quality of life, as opposed to simply wanting to reduce the number of medicines that they are receiving. Deprescribing decisions need to involve and consider the person's treatment choices, cultural and clinical needs.

Medication review

Medication review is usually considered to be a systematic, comprehensive and collaborative assessment of a person's medicines use and the management of those medicines. During medication review each medicine (existing and newly prescribed) is assessed to determine:

- ▶ Appropriateness for the individual
- ▶ Their experience or satisfaction with the outcomes of using the medicine, especially if it has been newly prescribed
- ▶ Expected treatment outcomes – for instance, its effectiveness for the medical condition
- ▶ Safety in the context of comorbidities and other medicines being taken – including whether inappropriate polypharmacy is an issue
- ▶ The ability for it to be taken by the individual as intended.

The focus of a medication review is the person's health, independence, care, comfort and safety.

Home Medicines Review

A **Home Medicines Review (HMR)**⁷⁴ is a collaborative medication review provided in accordance with a program funded by the Australian Government for eligible people. HMRs are designed to support those living and/or receiving care in their homes. It is a service to people living at home and is a formalised medication review carried out within an agreed process. HMR is based on a team approach that involves the person's GP and preferred community pharmacy, and other relevant members of the healthcare team such as nurses, Aboriginal Health Workers, Torres Strait Islander Health Workers or other care workers.

When a person's GP believes that a person is having problems with managing their medicines and that they would benefit from an HMR, the GP can arrange the review with their consent. A GP can also arrange an HMR following a request from a pharmacist, nurse, Aboriginal Health Worker, Torres Strait Islander Health Worker, the individual and/or their carer, or other healthcare professional.



The HMR should be conducted in the patient's home, however alternative locations can be requested, with prior approval from the HMR Program administrator, if there are safety or cultural circumstances preventing the service being delivered within the home. It is preferable to conduct the HMR in the individual's home.

Some examples of risk factors known to predispose people to medicines-related problems include:

- ▶ Taking five or more regular medications (polypharmacy) or more than 12 doses of medicines a day
- ▶ Significant changes made to the medicines regimen in the last three months
- ▶ Medicines with a narrow therapeutic index or requiring therapeutic monitoring
- ▶ Symptoms suggestive of an adverse drug reaction
- ▶ Sub-therapeutic response to treatment with medicines
- ▶ An inability to manage medicines-related devices or follow the medicines regimen (intentional or not)
- ▶ Health literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties
- ▶ Recent discharge from hospital – for instance, in the past four weeks.

It is also recognised that there might be additional risk factors that should be considered, including a person's:

- ▶ Health conditions or lifestyle practices
- ▶ Use of complementary and/or non-prescription medicines.

MedsCheck

A **MedsCheck (or Diabetes MedsCheck) service**⁷⁵ is provided face-to-face by a pharmacist within a community pharmacy and consists of:

- ▶ Reviewing a person's medicines
- ▶ Evaluating their knowledge and understanding of their medicines
- ▶ Addressing any problems identified
- ▶ Providing advice about a person's medicines.

A person must meet eligibility criteria and informed consent must be obtained.

Implementation – key tasks and strategies

For the providers of community healthcare services

It is recommended that community healthcare service providers have access to a person's medication management plan to identify and confirm the need for ongoing and/or additional support with their medicines. The healthcare professional or care worker will need to request and seek permission from the person to access their individualised medication management plan, so that they are able to respond to ongoing and/or additional service requirements accordingly – especially if a person's medicines have recently been reviewed by their GP and/or pharmacist.

For healthcare professionals

As part of good quality care, it is essential that all medicines be reviewed regularly by the relevant healthcare professional. For instance, whenever a decision is being made about the prescribing of a medicine by a prescriber, the dispensing of a medicine by a pharmacist or the administration of a medicine by a registered nurse.

A comprehensive medication review needs to be undertaken in accordance with the relevant **professional guidelines**.⁷⁶ Reviews need to involve collaboration between the individual, their carer and/or family and relevant members of the healthcare team – for example, the individual's GP, pharmacist, nurse, other healthcare professionals, Aboriginal Health Workers and Torres Strait Islander Health Workers and other care workers (however titled). If the review is to be conducted via telehealth, the person's willingness to do so and their access to the relevant technology will need to be confirmed.

Results from a medication review – for instance, HMR – are to be documented by the pharmacist. Ideally, an individualised medication management plan is developed and used as a communication tool, detailing the intended goals of care along with follow-up actions or recommendations (refer to **Guiding Principle 2: Communicating about medicines**).

If, as a result of any follow-up actions or recommendations, changes are made to a person's medicines, these are to be documented by the person's prescriber (for instance, their GP) within the person's progress notes. This can be on their medication chart (paper-based or electronic equivalent) or within a general practice management system, and the person's medicines list updated accordingly (refer to **Guiding Principle 8: Medicines list**).

For the individual, their carer and/or family

The need for a medication review for a person can be identified by the person's GP, the pharmacist, nurse or other healthcare service providers.

An individual, their carer, family and/or substitute decision-maker can also request for their medicines to be reviewed at any time by their GP or pharmacist. This includes requesting a comprehensive medication review – for example, HMR, or alternatively requesting a MedsCheck from a community pharmacist.

During an HMR, an accredited pharmacist comprehensively reviews the person's medicines regimen (including prescription, complementary and non-prescription medicines). The pharmacist will discuss with the individual, their carer and/or family, how the individual takes their medicines and any difficulties or uncertainties about them. The pharmacist will then discuss the results of the home visit (or telehealth consultation) with the individual's GP. The GP can then follow up with the person to agree on and implement a medication management plan, including the intended goals. This may also need to involve the individual's carer and/or family, and/or community healthcare service provider.

A face-to-face MedsCheck by a pharmacist within a community pharmacy does not require a follow up by a GP. However, if concerns are identified by the pharmacist these may need to be communicated to the individual's GP.

Resources



A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

Reflective questions



What information is made available to people about the range and purpose of medication review services that are available to them?



If using visual and audio technology for a telehealth medication review consultation, how does the healthcare professional gain the person's consent and willingness to do so, and ensure that they have access to the required technology?

Alteration of solid oral dose forms

Alteration of solid oral dose forms of medicines, such as crushing tablets, should be avoided. However, if a person is suffering from swallowing difficulties:

- ▶ Suitable alternative formulations (or medicines) should be sought
- ▶ The person should be provided with the information and help they need to ensure their medicines can be administered safely and effectively.

Summary and intent

Wherever possible solid oral dose forms of medicines should not be altered or crushed and alternatives should be sought – for instance, dispersible tablets or liquid preparations, or via an alternative methods of administration (via injection or dermal patch).

Alteration of oral dose forms is common in aged care⁷⁷ as well as for those with a disability, with crushing of oral tablets the most common alteration. Other common practices include mixing oral dose forms with liquids or food. The potential for toxicity, reduced efficacy of the medicine or changes to the stability of the medicine can occur when oral dose forms are altered.

Some medicines must not be altered at all, for instance, enteric-coated, modified or slow-release formulations. If administration is an issue, an alternative medicine or different formulation of the medicine needs to be considered. Alternative formulations that may be available include dispersible tablets, liquids, topical applications, patches, intranasal sprays, suppositories, injections or stable extemporaneous mixtures.

If there is no suitable alternative formulation, alteration or crushing must not result in reduced effectiveness or increased risk of toxicity. Expert advice from a pharmacist and use of appropriate evidence-based information will assist when the decision is being made to alter or crush an oral dose form of a medicine. This includes avoiding an unacceptable presentation in terms of taste or texture, or a risk to work, health and safety when handling some medicines, for instance, cytotoxic medicines.

Where equipment or tools are used for crushing or mixing a medicine, they need to be cleaned properly between medicines.

For detailed information and guidance about alteration of oral dose forms, nurses should be encouraged to use the latest edition of the Society of Hospital Pharmacists Australia (SHPA) *Don't Rush to Crush*⁷⁸ publication.

Key terms

All technical terms in these Guiding Principles are defined in the *[Glossary for the Guiding Principles and User Guide](#)*. This section provides background, contextual and additional information on the use of key terms in the specific context of this Guiding Principle.

Dysphagia

Some people have swallowing difficulties (dysphagia), and choking is a major cause of preventable deaths.⁷⁹ Some medicines are known to cause or worsen existing problems with swallowing – for instance, antipsychotic medicines. For people with dysphagia, either temporary or permanent, it can be difficult to take or administer solid oral dose forms of medicines.

Dysphagia is a condition that affects both the young and old and represents a significant risk to people's safety and wellbeing. While Australians are alert to the choking risks for small children, few know the danger of choking on food is seven times greater for people aged over 65 years than those aged one to four years.⁷⁹

Where it is unsafe for a person to swallow oral dose forms of medicines, such as tablets and capsules, ideally the person should be assessed by a healthcare professional – for instance, a speech pathologist.

Implementation – key tasks and strategies

For the providers of community healthcare services

Altering solid oral dose forms by means such as crushing tablets or opening capsules can make it easier to administer a medicine to a person who has difficulty in swallowing – for instance, an older person being cared for in their home, or a person with a disability who has a problem with swallowing.

Expert advice from a pharmacist and/or the person's GP must be sought by community healthcare service providers that do not have the professional expertise to make the decision to alter a solid oral dose form of a medicine. The individual, their carer and/or family should be encouraged to seek advice from their pharmacist or GP.

Community pharmacies need to ensure their workforce has access to current information about alteration of oral dose forms of medicines. This can include standard operating procedures and medicines information resources such as:

- ▶ *[Australian Medicines Handbook](#)* (AMH)⁸⁰
- ▶ *[Australian Pharmaceutical Formulary and Handbook](#)* (APF)⁸¹
- ▶ Australian SHPA *[Don't Rush to Crush](#)*⁷⁸ publication.

Care workers must not alter a medicine without instruction from the individual's prescriber or other relevant healthcare professional. Before assisting a person to take their medicines, care workers should ask people whether they have any difficulties in swallowing any of their medicines and check labels on the medicine containers or dose administration aid (DAA) for any instructions about altering oral dosage forms (for example, 'do not crush or chew'). Care workers who are asked to alter solid oral dose forms against the advice of the prescriber, pharmacist or healthcare service organisation must refer the matter to their supervisor. Care workers need to be guided by their organisation's policies, procedures and guidelines on medication management.

If solid oral dose forms of medicines are to be altered, it is also important to understand how to avoid an unacceptable presentation in terms of taste or texture, or a risk to work health and safety when handling some medicines, for instance, cytotoxic medicines. In addition, adequate fluid needs to be given with altered dose forms to aid ingestion.

Specialised equipment or tools, such as a pill crusher or a mortar and pestle, can be sourced and used for crushing or mixing a medicine. Depending upon the device, it needs to be cleaned properly between medicines. In addition, cross-contamination of one person's medicine with that of another can occur where the same crushing tool is used for more than one person. This can have serious consequences – for instance, if a person is allergic to a medicine such as penicillin.

For healthcare professionals

As some people will not report or admit to difficulties in swallowing, everyone being prescribed or dispensed a medicine should be advised not to alter their medicines in any way. Healthcare professionals should routinely ask people whether they have any difficulties in swallowing any of their medicines, and respond to any reported or noted difficulties, especially if the oral dose form of the medicine cannot be altered.

Where a different oral formulation (including an extemporaneous mixture) or an alternative medicine is not possible, alteration of an oral dose form of a medicine may be necessary. However, for detailed information and guidance about alteration of oral dose forms healthcare professionals should initially refer to a suitable resource – for instance, the latest edition of the Australian SHPA *Don't Rush to Crush*⁷⁸ publication.

If a decision is made to alter an oral dose form of a medicine, either temporarily or on an ongoing basis for an individual, this should be documented in their healthcare record, along with the rationale for this decision.

Medication management reviews, including **Home Medicines Reviews (HMRs)**⁷⁴ and **MedsChecks**⁷⁵, are means of identifying individuals who have problems swallowing, including individuals who might be altering oral dose forms of their medicines in spite of previous advice. Perceived or actual swallowing difficulties might trigger referral for such a review. Whilst they interview the person, the pharmacist can ask about the medicines that they are taking and how they take them and if necessary consult the prescriber (in the case of HMR, the individual's GP) about a change in formulation or prescribing another medicine.

Information about any difficulties, such as swallowing, that might result in people altering the solid oral forms of their medicines should also be sought, with the individual's permission, from those helping them to manage their medicines – for example, their carer and/or family, healthcare professionals, and care workers. People experiencing increasing difficulty in swallowing may require further assessment by their primary care provider (for instance, their GP) and referral to a speech pathologist. The pharmacist can include this as a recommendation within their medication management review report (refer to **Guiding Principle 9: Medication review**).

This advice also applies to non-oral dose forms such as topical patches.

For the individual, their carer and/or family

When a person finds it difficult to swallow, the individual, their carer and/or family member who assists them to take their medicines should be encouraged to advise their primary care provider or GP, and/or their pharmacist. This is important as some formulations of medicines must not be crushed (or even chewed) due to special coatings or slow-release properties.

At the time of prescribing and dispensing, people should be provided with information on whether solid oral dose formulations of their medicines can be altered. For example, the information could be in the form of verbal instruction, consumer medicine information (CMI), and/or included when labelling the medicine container – for instance, a cautionary advisory label (CAL).

A pill crusher may be a useful tool for use at home if a medicine a person is taking is suitable for crushing. Adequate fluid needs to be taken with altered oral dose forms to aid ingestion as it is important to ensure that if a medicine can be crushed, it can be easily swallowed. For instance, once mixed with a small amount of semi-solid food (or other suitable substance) and swallowed, it should be followed with sufficient water to ensure that the medicine has passed into the stomach.^{77,79}

Resources



A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

Reflective questions



What policies, procedures and guidelines are in place on the alteration of dose forms of oral medicines?



How does the healthcare professional ensure they have access to the most current and evidence-based information on the suitability for medicines to be crushed or altered prior to administration or self-administration?



What information on alteration of oral dose forms is provided to individuals who are administering medicines in their home?

Storage and disposal of medicines

All those using medicines in the community should store medicines in a manner that:

- ▶ Maintains the quality of the medicines
- ▶ Minimises wastage
- ▶ Safeguards the person, the person's family and visitors in their home.

Unwanted, ceased or expired medicines should be disposed of safely to avoid accidental harm and misuse in a sustainable and environmentally appropriate manner.

Summary and intent

Storage of medicines

The stability or effectiveness of some medicines depends on storing them at the correct temperature, for example, temperature-sensitive medicines that require refrigeration.

Ideally, medicines should be stored in their original container in a cool (preferably below 25°C), dry and secure place, according to the manufacturer's instructions within the medicine's product information or consumer medicines information (CMI) leaflet.

Community pharmacies and healthcare settings have additional responsibilities relating to the supply chain and storage of medicines. This includes:

- ▶ Systems to maintain the integrity of medicines – for instance, using effective storage and cold-chain response systems that ensure the integrity and efficacy of vaccines and other cold storage medicines in accordance with **National Vaccine Storage Guidelines – Strive for 5**⁸²

- ▶ Legislative requirements – for example, ensuring Schedule 8 medicines are separately secured and accounted for (and disposed of) according to state and territory legislative requirements.

*Principles for the safe selection and storage of medicines: Guidance on the principles and survey tool*⁸³ provides information on the strategies and principles to ensure safe storage and selection of medicines. The principles developed for health service organisations can be applied within community pharmacy or other settings where medicines are stored by healthcare service providers.

Healthcare professionals and care workers (however titled) should advise people on the importance of storing medicines properly and in accordance with any instructions on the medicine label – including cautionary advisory labels (CALs) or within the CMI.

In addition, advice should be provided on storing high-risk medicines, such as Schedule 8 medicines, securely and out of sight when not in use.

Disposal of medicines

Medicines disposal should be managed to ensure the safe and appropriate disposal of peoples' unwanted and expired medicines (including dose administration aids and other devices).^{*} Cytotoxic medicines must be segregated and disposed according to state or territory legislation. Storage of unwanted and expired medicines can be dangerous and can lead to unintended poisoning. Any medicines older than the expiry or use-by date should be disposed of.

All medicines that are unwanted (including unused), have been ceased or have expired should be disposed of in a way that is safe and reflects best practice and in accordance with the relevant state or territory legislation. For links to the relevant state or territory legislation, refer to the [Resources](#) list for Guiding Principle 4: Information resources.

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

If healthcare professionals, service providers or care workers identify the need for disposal of medicines, this should only occur once consent has been obtained from the individual, their carer and/or family.

Unwanted medicines are to be disposed of in accordance with regulatory and state or territory environment protection authority requirements. The [Return Unwanted Medicines \(RUM\) Project](#)⁸⁴ is an example of a medicines disposal program.

It is important that sharp objects (also referred to as 'sharps') such as needles and syringes are not collected under the RUM Project due to the danger of needlestick injuries to workers. All 'sharps' should be placed in an appropriate container – for instance, an Australian standard yellow sharps container, and disposed of separately according to local arrangements.

^{*} Devices include: inhalers and insulin pens and exclude 'sharps'

Implementation – key tasks and strategies

For the providers of community healthcare services

Where there is a major risk of medicine misuse, such as accidental overdose by people who are diagnosed with confusion or dementia, the healthcare service provider (in conjunction with the individual's carer and/or family) might need to take a lead role in making sure that the medicines are appropriately secured.

In such cases, medicines will need to be stored out of the person's reach and sight, while still being accessible to those assisting in the person's medication management. For example, medicines could be stored in a locked box in the top of the pantry or kitchen cupboard.

Particular care must be taken to ensure that sharp objects (or 'sharps') such as needles and syringes are also stored and disposed of safely.

Community healthcare service providers should have policies, procedures and guidelines in place about the safe disposal of medicines and related equipment, such as 'sharps' and cytotoxic medicines. If a person does not have access to a mechanism for safe disposal of 'sharps' – for instance, in an appropriate container – the care worker or healthcare professional should discuss access and use of an appropriate container in accordance with the service provider's policies, procedures and guidelines.

Suitable containers for disposal of 'sharps' include:

- ▶ Australian standard yellow sharps containers which can be purchased from a community pharmacy
- ▶ A strong container that cannot be pierced by a sharp object, made from heavy/thick plastic and a tight fitting or childproof lid – for example, a plastic bleach bottle.

Used 'sharps' containers should be taken to a community sharps disposal facility for safe disposal.

For the healthcare workforce

When a person needs to move their medicines out of the home, the healthcare professional – for instance, the pharmacist, should provide information about

suitable storage and transport of their medicines. For example, medicines that are normally stored in the fridge can be put in a small, insulated lunchbox along with an ice brick.

The healthcare professional should also advise people to keep their medicines in the original packaging and to observe the directions on the label for safe storage. Care workers should seek further advice from a community nurse, pharmacist or an individual's prescriber if they have concerns about transporting an individual's medicine.

Medicines return and disposal practices may provide quality assurance feedback. For example, monitoring of returned, unused medicines in dose administration aids (DAAs) may assist an individual's pharmacist and/or prescriber in gauging adherence to treatment plans.

For people being administered cancer chemotherapy (cytotoxic medicines) in their own homes, the healthcare professional or registered nurse who is responsible for administering these medicines, needs to make sure that the individual, their carer and/or family and if necessary, other care workers, are provided with the necessary information to ensure the health and safety of everyone in the person's home. Such information should reflect national, and relevant state or territory legislation, and include advice on home storage of cytotoxic medicines and the management of cytotoxic waste – including secure storage of cytotoxic waste and precautions when transporting waste containers.

Where a Home Medicines Review (HMR) is being conducted for an individual, there is an opportunity to discuss, recommend and seek their permission to dispose of unwanted and expired prescription, complementary and non-prescription medicines.

For the individual, their carer and/or family

People who need help in managing their medicines at home might also need help to understand how to store them safely – for instance, people who might be unable to read or understand labels. This includes understanding that medicines should also be stored and kept safely away from children and animals.

The individual, their carer and/or family should regularly review the medicines they keep for self-administration when determining unwanted and expired prescription, complementary and non-prescription medicines by:

- ▶ Checking the expiry date on the label
- ▶ Alerting the prescriber, nurse or pharmacist when medicines may no longer be needed. This may be prescribed medicines where the prescription has changed, or non-prescription medicines that are no longer used.

Medicines should not be disposed of via the sewerage system or in landfill, hence should not be flushed down the toilet or put in the rubbish bin.

Everyone who uses medicines, their carer and/or family should be encouraged and provided information on how to return any unwanted, ceased or expired medicines to their local community pharmacy for safe disposal. In addition, following the death of a person, their carer or family should be encouraged to return all the deceased person's medicines to their community pharmacy for safe disposal.

As an example, the RUM Project allows people to return unwanted medicines and devices (including DAAs, inhalers and insulin pens) to any community pharmacy within Australia for safe disposal. The Therapeutic Goods Administration (TGA) has developed [consumer resources explaining why safe disposal of medicines is important](#)⁸⁵ and how to access the RUM Project.

Disposal of needles and syringes cannot occur through the RUM Project and must be disposed of separately. People who routinely use needles and syringes should seek advice from their pharmacist about needle and syringe disposal programs in their state or territory.

Resources



A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

Reflective questions



How do those involved in a person's care ensure that all their medicines (including temperature-sensitive medicines) are stored appropriately?



What information is provided by community healthcare service providers to ensure people know how to dispose of medicines in an appropriate and environmentally safe manner?

Authorised initiation of medicines in the community

In accordance with national, state or territory legislation, only those authorised to do so should initiate medicines upon a person's request for the relief of minor symptoms or conditions/ailments.

Community healthcare service providers should develop policies, procedures and guidelines on:

- ▶ Initiation of prescription and non-prescription medicines
- ▶ Use and review of prescription medicines treatment protocols.

Summary and intent

This Guiding Principle relates to the authorised initiation, selection and administration of:

- ▶ Non-prescription medicines for minor symptoms or conditions/ailments
- ▶ Medicines prescribed using a medicines treatment protocol.

Authorised initiation of medicines

An individual, their carer and/or family may approach a range of healthcare practitioners – for instance, a prescriber, pharmacist or nurse – about the relief of minor symptoms and conditions/ailments. Such requests may result in the use of non-prescription or 'over the counter' (OTC) medicines.

In the community, pharmacists can initiate non-prescription medicines and Schedule 3 Pharmacist Only Medicines, either upon direct request from a person or to treat a minor ailment and in accordance with **Professional Practice Standards**.⁵⁷

Pharmacists are also able to supply prescription medicines in an emergency, without a valid prescription. For instance, under relevant national and state or territory legislation a pharmacist can issue a three-day emergency supply of some prescription medicines if a person's primary healthcare provider cannot be contacted, and continuation of a medicine is essential. Pharmacists are also authorised to supply medicines in an emergency under 'continued dispensing' arrangements for Pharmaceutical Benefits Scheme medicines.

Nurses require authorisation to select and administer non-prescription medicines to a person in their home. Depending upon state or territory legislation, nurse-initiation may involve the selection and administration of a medicine by a registered nurse (or enrolled nurse working under the supervision of a registered nurse) from an approved list of non-prescription (unscheduled, Schedule 2 and Schedule 3) medicines.

Not all healthcare service providers will approve nurse-initiated non-prescription medicines. However, healthcare service providers should:

- ▶ Consider whether there is a need for non-prescription medicines to be initiated by nurses within their service
- ▶ Develop policies, procedures and guidelines in consultation with prescribers and pharmacists to assist nurses in safely initiating these medicines in a person's home
- ▶ Distribute their policies, procedures and guidelines – including the list of relevant non-prescription medicines to all authorised prescribers who refer people to the service.

While the non-prescription medicines authorised for nurse-initiation should be of low risk, the registered nurse initiating a non-prescription medicine must execute appropriate due-diligence in assessing the need and appropriateness of a specific medicine.

Prescription medicine treatment protocols (however titled)

Some states and territories may permit the use of treatment protocols (sometimes known as 'standing orders') where a nurse or Aboriginal Health Practitioner may initiate treatment with a prescription-only medicine under the protocol, usually only for urgent or emergency care. In most states and territories, prescription medicine treatment protocols can only be issued by a medical practitioner; these protocols must meet the state or territory legislative requirements, and if permitted, must be:

- ▶ For the administration of a specific medicine(s) for a specific condition
- ▶ Used by a registered nurse or a registered Aboriginal Health Practitioner
- ▶ Time limited.

However, there are circumstances where legislation does allow for a prescription medicine treatment protocol to be endorsed according to healthcare service policy to authorise an Aboriginal Health Practitioner to initiate a prescription-only medicine(s). Examples include: in accordance with the Central Australian Rural Practitioners Association (CARPA) **Remote Primary Health Care Manuals**⁸⁶, in particular, the *Medicines Book for Aboriginal and Torres Strait Islander Health Practitioners*.⁸⁷

Use of a prescription medicine protocol requires clinical judgement, and the registered nurse must first assess the specific circumstances for the individual involved.

Key terms

All technical terms in these Guiding Principles are defined in the *Glossary for the Guiding Principles and User Guide*. This section provides background, contextual and additional information on the use of key terms in the specific context of this Guiding Principle.

Non-prescription medicines initiated for minor symptoms or conditions/ailments

A person, their carer or family may ask a nurse or care worker about the relief of minor symptoms and conditions/ailments. Such requests may result in the use of non-prescription or over-the-counter (OTC) medicines. These are often referred to as 'non-prescription nurse-initiated medicines' (NIMs).

Depending upon state or territory legislation, authorised initiation may involve the selection and administration of a medicine by a registered nurse (or enrolled nurse working under the supervision of a registered nurse) from an approved list of non-prescription (unscheduled, Schedule 2 and Schedule 3) medicines endorsed by the clinical governance committee. Prior agreement of the person's medical practitioner may be required. Irrespective of state and territory legislation, the range of medicines should be limited and might include:

- ▶ Oral paracetamol for pain
- ▶ An antacid for indigestion
- ▶ Docusate sodium plus senna for constipation.

While any non-prescription medicines authorised for initiation should be of low risk, the healthcare professional initiating a non-prescription medicine must still execute appropriate due diligence in assessing the need and appropriateness of a specific medicine.

Prescription medicine treatment protocols

Prescription medicine treatment protocols for Schedule 4 and Schedule 8 medicines can only be used to authorise the administration of a medicine to an individual in a particular circumstance and in accordance with a specified protocol and must comply with the relevant state or territory legislative requirements. The protocols are often used in situations where a prompt response using a standard procedure will improve a person's care and where a medicine is part of this procedure. This can include management of acute exacerbations of a chronic disease.



PRN medicines

A prescription medicine treatment protocol is not a 'when required' (*pro re nata*: 'PRN') medicine order. PRN medicine orders provide instructions for administration of medicines to a specific person when required in circumstances specified by the prescriber – for instance, in response to a person's symptoms rather than on a routine basis, even if the indication for use is obvious. PRN medicine orders should also include a maximum dose. Anticipatory prescribing is an example where PRN medicine orders are used.

Palliative care and anticipatory prescribing

Best practice management of a person's symptoms in their last days of life is one of the concerns of an individual, their carer and/or family. The use of anticipatory prescribing allows prescribers to provide effective guidance to authorised healthcare professionals – for instance, palliative care nurses, when they are assessing and managing a person's symptoms and making them comfortable. This includes anticipatory prescribing of PRN doses of medicines – for instance, via subcutaneous injection, for specific symptoms commonly faced by individuals in the terminal phase of their illness. Regular doses of medicines can also be ordered and administered via a syringe driver device over a 24-hour period, with intermittent doses via subcutaneous injection to control breakthrough symptoms.

The Clinical Excellence Commission (CEC) in NSW has developed a **toolkit**⁸⁸ for prescribing medicines in the last days of life – including an implementation guide: ***Guidance for Prescribing Last Days of Life Medications – Adult Patients***.⁸⁹ The guidelines and flowcharts have been developed for use in a hospital setting; however, they are also suitable for use in a community setting. In other states and territories, their use would need to be in accordance with the relevant state and territory legislation. NSW community pharmacies are also recommended to stock items from a list of **core palliative care medicines**⁹⁰ for people being cared for in their home.

Implementation – key tasks and strategies

For the providers of healthcare services

The community healthcare service provider needs to:

- ▶ Assess the need for authorised initiation of non-prescription medicines by nurses and/or Aboriginal Health Practitioners
- ▶ Have information available on how a person being supported in their home can seek advice or treatment for the relief of minor symptoms and conditions/ailments
- ▶ Include advice on the reporting all suspected allergies or adverse reactions to a medicine(s) along with medication incidents (refer to **Guiding Principle 3: Governance and risk management of medicines use in the community**).

Policies, procedures and guidelines need to be developed in consultation with medical practitioners and pharmacists and they must comply with relevant state and territory legislation. Mechanisms for consultation can be via clinical governance committees, Primary Healthcare Networks, or with individual doctors and pharmacists.

An agreed list of non-prescription medicines that can be initiated in a person's home for the relief of minor symptoms and conditions/ailments should be developed. This needs to include information about each medicine, including indications for use, dosage ranges, precautions and contra-indications. The healthcare service provider should ensure the list of nurse-initiated medicines is reviewed regularly.

Healthcare service providers should make available a copy of their policies, procedures and guidelines, including the list of medicines, for all authorised prescribers who refer people to the service.

In all circumstances, it is recommended that the person's primary healthcare provider (for instance, their GP) is advised if a person requests a non-prescription medicine. If the use of a non-prescription medicine becomes routine, the authorised prescriber should review the person's use of the medicine.

For non-prescription medicines, policies, procedures and guidelines need to include:

- ▶ How to ensure that the individual receiving support or care in their home, their carer and their medical practitioner has consented to a nurse or Aboriginal Health Practitioner initiating non-prescription medicines
- ▶ That the medicines are only appropriate for once-only or occasional use
- ▶ Sufficient detail to ensure that nurses or Aboriginal Health Practitioners can make informed decisions as to when and when not to select and administer a medicine from an approved list, including assessment, dosage, indications, and special precautions
- ▶ Where and how to document the administration – for instance, within the 'nurse-initiated' section of the person's medication chart (paper-based or electronic)
- ▶ What to do if the use needs to become routine or ongoing – for instance, review by the person's GP, and if required, formally prescribed and documented to guide administration.

Information about any doses of nurse or Aboriginal Health Practitioner-initiated medicine administered to an individual should be accessible to the individual's carer and/or family, other healthcare professionals and care workers.

If a care worker is approached by a person in their home and requested to access a medicine that is not documented on the medication management plan or medicines list, they should refer this request to their supervisor.

In circumstances where prescription medicine treatment protocols are required – for example, in rural and remote areas and some immunisation programs – healthcare service providers should develop policies, procedures and guidelines that describe the authorisation, use and routine monitoring in accordance with relevant state and territory legislation.

Policies, procedures and protocols for the use of prescription medicine treatment protocols must:

- ▶ Be condition-specific and time-limited
- ▶ Be supported by and linked to appropriate clinical assessment
- ▶ Be clearly written, dated and signed by a medical practitioner – for instance, the person's GP
- ▶ Be regularly reviewed by a medical practitioner
- ▶ Specify the medicine, dose, route and frequency for use
- ▶ Clearly identify under what circumstances a person is to be given the medicine, and when it is to be avoided
- ▶ Note any special observations or care that may be required before or after administration of the medicine
- ▶ Identify by qualification (for example, registered nurse) who may administer the medicine.

Each healthcare service provider also needs to ensure:

- ▶ The use of prescription medicine treatment protocols within the service is regularly monitored and reviewed
- ▶ Those healthcare professionals authorised to use prescription medicine treatment protocols understand their roles and obligations
- ▶ Appropriate education and training is in place for the use of prescription medicine treatment protocols.

For healthcare professionals

Should there be an identified need, registered nurses and Aboriginal Health Practitioners require appropriate authorisation from healthcare service providers to administer non-prescription medicines in a person's home.

The decision to use a prescription medicine treatment protocol is a clinical judgement and should be applied following an assessment of an individual, including where a prompt response is required.

When considering initiating a prescription or non-prescription medicine for a person, the healthcare professional should consider any known allergies or previous adverse reactions to medicines experienced by the person.

If a health professional initiates a non-prescription or prescription medicine in an individual's home, the individual's carer and/or family should also be consulted.

Administration of all prescription and non-prescription medicines in an individual's home must be recorded on the person's medication chart (paper-based or electronic).

Suspected allergies or adverse reactions to a medicine(s) along with medication incidents should be reported in accordance with the healthcare service provider's policies, procedures and guidelines (refer to **Guiding Principle 3: Governance and risk management of medicines use in the community**).

Nurse immunisers and pharmacists who administer vaccinations must follow the relevant immunisation standards, guidelines and state and territory legislative requirements. The person's immunisation status should be updated and recorded within the person's medical record – for instance, the general practice management system, and reported to the [Australian Immunisation Register \(AIR\)](#).⁹¹

For the individual, their carer and/or family

An individual, their carer and/or family have the right to request advice or treatment for the relief of minor symptoms and conditions/ailments from their healthcare professionals – for instance, a pharmacist, nurse or Aboriginal Health Practitioner.

Depending upon an individual's circumstances, they may undergo a clinical assessment in their home by a healthcare professional – for instance, a community nurse, palliative care nurse or Aboriginal Health Practitioner. This clinical assessment may result in the administration of a medicine according to a standard procedure that has not been prescribed by the person's medical practitioner yet is required where a prompt response is necessary. The person's carer and/or family will also be consulted.

Resources



A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

Reflective questions



How does the community healthcare service provider ensure its medication management policies, procedures and guidelines for authorised initiation of medicines are consistent with the requirements of relevant state or territory legislation?



If the healthcare service provider has an approved list of non-prescription medicines for authorised initiation, what mechanism is in place for the periodic review of this list as part of a quality-use-of-medicines (QUM) activity?



How does the healthcare service provider ensure that the administration and outcomes of authorised initiation of non-prescription medicines are recorded and reviewed?



If used and allowed by state or territory legislation, what process is in place to support the review, monitoring and use of prescription medicine treatment protocols (however titled) to ensure compliance?

Resources

Guiding Principle Relevant resources

GUIDING PRINCIPLE

1

- ▶ Aged Care Quality and Safety Commission (ACQSC)
 - [Charter of Aged Care Rights](#)⁸
 - [Aged Care Quality Standards](#)⁹²
 - [Guidance and resources for providers to support the Aged Care Quality Standards](#)⁹³
 - [Minimising use of restrictive practices](#)⁹⁴
 - [Consumer resource library](#)⁹⁵
- ▶ [Agency for Healthcare Research and Quality \(AHRQ\)](#)⁹⁶
- ▶ [The Patient Education Materials Assessment Tool \(PEMAT\) and User's Guide](#)⁹⁷
- ▶ Australian Commission on Safety and Quality in Health Care (ACSQHC)
 - [Australian Charter of Healthcare Rights](#)⁷
 - National Safety and Quality Health Service (NSQHS) [Partnering with Consumers Standard](#)⁹⁸
 - [National Safety and Quality Primary and Community Healthcare Standards](#)¹⁶
 - [Person-centred care](#)⁹⁹
 - [Informed consent](#)¹⁰⁰
 - [Health literacy](#)¹⁰¹
 - [Shared decision making](#)¹⁰²
 - [Tips for safe health care](#)¹⁰³
 - [Understanding your rights](#)¹⁰⁴
 - [My Healthcare Rights – A guide for people with cognitive impairment](#)¹⁰⁵
 - [Information for consumers](#)¹⁰⁶
 - [Identify goals of care](#)¹⁰⁷
 - [Working with your healthcare provider](#)¹⁰⁸
 - [Finding good health information](#)¹⁰⁹
 - [Translated information](#)¹¹⁰
 - [National Standard for labelling dispensed medicines](#)¹¹¹
 - [Consumer representation guide for partnering with consumers](#)¹¹²

Guiding Principle Relevant resources

Guiding Principle 1 (continued)

- ▶ Australian Health Practitioner Regulation Agency (Ahpra) **Aboriginal and Torres Strait Islander Health Strategy**¹¹³
 - Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025
 - Reconciliation Action Plan
 - Statement of Intent
 - Cultural safety definition
- ▶ Australian Government
 - **Healthdirect**¹¹⁴
 - **Style Manual: Cultural and linguistic diversity**¹¹⁵
 - **Head to Health**¹¹⁶ digital health resources
 - **Culturally and linguistically diverse people**¹¹⁷
- ▶ Australian Medical Association (AMA) **AMA position statement – complementary medicine – 2018**¹¹⁸
- ▶ Choosing Wisely Australia
 - **Consumers and carers**¹¹⁹
 - **5 questions to ask your doctor or other healthcare provider before treatment**¹²⁰
- ▶ HealthWest Partnership and Inner North West Primary Care Partnership **Make it Easy: A handbook for becoming a health literate organisation**¹²¹
- ▶ National Aboriginal Community Controlled Health Organisation (NACCHO) **Medicines Management Network and Resources**¹²²
- ▶ NPS MedicineWise¹²³
- ▶ Older Persons Advocacy Network (OPAN) **Medication: It's Your Choice**¹²⁴
- ▶ Sydney Health Literacy Lab (SHeLL)¹²⁵ **Health Literacy Editor**¹²⁶
- ▶ Victorian Government Department of Health **Improving access – fact sheets for clinicians**¹²⁷
 - **An interdisciplinary approach to caring**¹²⁸
 - **Improving communication**¹²⁹
- ▶ World Health Organization (WHO) **global strategy on people-centred and integrated health services: interim report (2015)**¹³⁰

GUIDING PRINCIPLE

2

- ▶ Australian Commission on Safety and Quality in Health Care (ACSQHC)
 - National Safety and Quality Health Service (NSQHS) **Communicating for Safety Standard**¹³¹
 - **National Safety and Quality Primary and Community Healthcare Standards**¹⁶
 - **Communicating for Safety resource portal**¹³²
- ▶ Bolton Clarke
 - **Information on Medicines in English – Talking Book**¹³³
 - **Medicine Reminder Cards**¹³⁴ in various languages
- ▶ NSW Transcultural Mental Health Centre¹³⁵
 - **Cross-cultural Mental Health Care: A resource for GPs and health professionals**¹³⁶
 - **Consumer medication brochures**¹³⁷

Guiding Principle Relevant resources



- ▶ **Anesthesia Patient Safety Foundation (APSF)¹³⁸**
- ▶ Australian Government
 - **Commonwealth Home Support Program²³**
 - **Home Care Packages Program¹³⁹**
 - **My Aged Care Home Support Programme¹⁴⁰**
 - **Responsibilities-of-home-care-package providers²⁴**
- ▶ Australian Commission on Safety and Quality in Health Care (ACSQHC)
 - **National Safety and Quality Primary and Community Healthcare Standards¹⁶**
 - **Incident Management Guide¹³**
 - **State and territory incident management resources³⁹**
 - **Australian Open Disclosure Framework⁴⁰**
 - **Open Disclosure resources for health service organisations¹⁴¹**
 - **Open disclosure of things that don't go to plan in health care – A booklet for patients beginning an open disclosure process¹⁴²**
 - **National Model Clinical Governance Framework¹⁴**
- ▶ NSW Clinical Excellence Commission (CEC)
 - **NSW Incident management policy resources¹⁴³**
 - **Quality improvement tools³⁴**
 - **Root case analysis (RCA) toolkit¹⁴⁴**
- ▶ Institute for Healthcare Improvement (IHI)³⁷
 - **Free resources and tools to guide improvement¹⁴⁵**
 - **Patient Safety Essentials Toolkit¹⁴⁶**
- ▶ Pharmaceutical Society of Australia (PSA)
 - **Clinical Governance Principles for Pharmacy Services (2018)¹⁴⁷**
 - **Code of Ethics for Pharmacists¹⁴⁸**
 - **Professional Practice Standards⁵⁷**
- ▶ Royal Australian College of General Practitioners (RACGP)
 - **A guide to manage clinical risks, errors, near-misses and adverse events¹⁴⁹**
 - **Definition: What is General Practice?¹⁵⁰**
 - **General Practice Patient Charter¹⁵¹**
 - **Resources to improve the safety and quality of general practice¹⁵²**
- ▶ **SafetyCulture¹⁵³ Incident report guide¹⁵⁴**
- ▶ Sample medication incident/error forms
 - **Medication error form¹⁵⁵**
 - **Medication Incident Report Form¹⁵⁶ (Queensland Government)**
 - **Incident decision tree¹⁵⁷**
- ▶ Western Victoria Primary Healthcare Network (PHN) **Quality Improvement in General Practice¹⁵⁸** – includes a PDSA template and sample PDSAs

Guiding Principle Relevant resources

GUIDING PRINCIPLE 4

The resources in this section are broadly grouped into legislation, regulation and standards for aged care, health professions and medicines; information resources about medicines, therapeutics, and services to support quality use of medicines (QUM); and tools and information to support individuals receiving care and their carer and/or family.

These resources may be additional to those also listed as relevant to each Guiding Principle.

To support providers of community healthcare services

Aged care regulation and standards:

- ▶ Australian Government
 - ***Aged Care Act 1997***¹⁵⁹ governs all aspects of the provision of residential care, flexible care and Community Aged Care for older Australians
 - ***Aged Care Quality and Safety Commission***¹⁶⁰ role is to protect and enhance the safety, health, wellbeing and quality of life of people receiving aged care
 - ***Aged Care Quality Standards***⁹² are assessed and monitored by the Aged Care Quality and Safety Commission. Aged care providers in Australia are expected to comply with these Standards

Restrictive practices:

- ▶ Australian Commission on Safety and Quality in Health Care (ACSQHC) ***Reducing inappropriate use of antipsychotics in people with behavioural and psychological symptoms of dementia (BPSD)***¹⁶¹ infographic
- ▶ Australian Government Aged Care Quality and Safety Commission (ACQSC)
 - ***Aged Care Quality Standard 8: Organisational governance***¹⁶² requires that clinical care be supported by a clinical governance framework that minimises the use of restraint or restrictive practices, including the use of medicines
 - ***Minimise the use of restrictive practices***⁹⁴ outlines specific responsibilities of approved aged care providers
 - ***Quality Care Principles 2014***¹⁶³
- ▶ Australian Government Department of Health and Aged Care
 - ***Aged Care Clinical Advisory Committee***¹⁶⁴ is tasked with considering the range of issues regarding the inappropriate use of chemical restraints in aged care
 - ***Revised Pharmaceutical Benefits Scheme (PBS) restrictions for behavioural and psychological symptoms of dementia (BPSD)***¹⁶⁵
 - ***Six steps for safe prescribing of antipsychotics and benzodiazepines in residential aged care***¹⁶⁶ provides information and resources that support the appropriate management of dementia in a residential aged care setting

Disability:

- ▶ ***National Disability Insurance Scheme (NDIS) Quality and Safeguards Commission***¹⁶⁷ ***Resources***¹⁶⁸ including practice alerts, provider updates and podcasts

Health literacy:

- ▶ Australian Commission on Safety and Quality in Health Care (ACSQHC) ***Writing health information for consumers***⁴⁶
- ▶ Australian Government ***Australian Government Style Manual***⁴⁷
- ▶ HealthWest Partnership and Inner North West Primary Care Partnership ***Make it Easy: A handbook for becoming a health literate organisation***¹²¹

| Guiding Principle | Relevant resources |
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| <p>Guiding Principle 4 (continued)</p> | <p>To support healthcare professionals</p> <p>Healthcare profession regulation, standards and guidelines:</p> <ul style="list-style-type: none"> ▶ Australian Health Practitioner Regulation Agency (Ahpra)¹⁶⁹ <i>Health Practitioner Regulation National Law Act 2009</i>⁶ ▶ Australian Nursing and Midwifery Federation (ANMF) Nursing Guidelines: Medication Management in Aged Care⁶³ ▶ Pharmaceutical Society of Australia (PSA) <ul style="list-style-type: none"> – Guidelines for pharmacists providing dose administration aid services⁵⁵ – Guidelines for Quality Use of Medicines (QUM) services¹⁷⁰ – Guidelines for comprehensive medication management reviews⁷⁶ – National Competency Standards¹⁷¹ – Professional Practice Standards⁵⁷ – Resource Hub¹⁷² ▶ Pharmacy Guild of Australia (PGA) <ul style="list-style-type: none"> – In-Home Care¹⁷³ – Quality Care Pharmacy Program (QCPP)¹⁷⁴ – Resources¹⁷⁵ ▶ Royal Australian College of General Practitioners (RACGP) <ul style="list-style-type: none"> – RACGP aged care clinical guide (Silver Book)⁷¹ – RACGP Guidelines¹⁷⁶ – Standards for General Practice²¹ ▶ Society of Hospital Pharmacists of Australia (SHPA) <ul style="list-style-type: none"> – Standards of Practice for Clinical Pharmacy Services¹⁷⁷ – Standard of practice in geriatric medicine for pharmacy services¹⁷⁸ describes best-practice provision of clinical pharmacy services for older people in hospitals, residential aged care facilities, transition care services and in the community ▶ The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Professional Practice Guideline 10: Antipsychotic medications as a treatment of behavioural and psychological symptoms of dementia¹⁷⁹ <p>Medicine legislation and regulation</p> <ul style="list-style-type: none"> ▶ Therapeutic Goods Administration (TGA) Standards for the Uniform Scheduling of Medicines and Poisons (SUSMP)¹⁸⁰ or 'The Poisons Standard' is a national 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 |

| Guiding Principle | Relevant resources |
|---------------------------------|--|
| Guiding Principle 4 (continued) | <p>Legislation for drugs, poisons, and medicines administration for states and territories:</p> <ul style="list-style-type: none"> ▶ Australian Capital Territory (ACT) <ul style="list-style-type: none"> – ACT Pharmaceutical Services¹⁸¹ – Medicines, Poisons and Therapeutic Goods Act 2008¹⁸² – Medicines, Poisons and Therapeutic Goods Regulation 2008¹⁸³ ▶ New South Wales (NSW) <ul style="list-style-type: none"> – NSW Health Pharmaceutical Services¹⁸⁴ – Poisons and Therapeutic Goods Act 1966 No. 31¹⁸⁵ – Poisons and Therapeutic Goods (Poisons List) Proclamation 2016¹⁸⁶ ▶ Northern Territory (NT) <ul style="list-style-type: none"> – NT Health. Medicines and poisons¹⁸⁷ – Medicines, Poisons and Therapeutic Goods Act 2012¹⁸⁸ – Medicines Poisons and Therapeutic Goods Regulations 2014¹⁸⁹ ▶ Queensland <ul style="list-style-type: none"> – Medicines and Poisons Act 2019¹⁹⁰ – Medicines and Poisons (Medicines) Regulation 2021¹⁹¹ – Medicines and Poisons (Poisons and Prohibited Substances) Regulation 2021¹⁹² – Medicines and Poisons (Pest Management Activities) Regulation 2021¹⁹³ – Therapeutic Goods Regulation 2021¹⁹⁴ ▶ Queensland Health <ul style="list-style-type: none"> – Medicines: Clinical guidelines and procedures¹⁹⁵ – New medicines, poisons and pest management regulatory framework¹⁹⁶ – Legislation, standards and extended practice authorities¹⁹⁷ – Substance management plans (SMPs) for medicines¹⁹⁸ ▶ South Australia (SA) <ul style="list-style-type: none"> – Medicines and Technology Programs¹⁹⁹ – Controlled substances legislation²⁰⁰ – Controlled Substances Act 1984²⁰¹ – Controlled Substances (Poisons) Regulations 2011²⁰² ▶ Tasmania <ul style="list-style-type: none"> – Tasmania Department of Health. Medicines and poisons regulation²⁰³ includes contact details for Pharmaceutical Services Branch – Poisons Act 1971²⁰⁴ – Poisons Regulations 2018²⁰⁵ ▶ Victoria <ul style="list-style-type: none"> – Victorian Government Department of Health Medicines and Poisons²⁰⁶ – Drugs, Poisons and Controlled Substances Act 1981²⁰⁷ – Drugs, Poisons and Controlled Substances Regulations 2017²⁰⁸ ▶ Western Australia (WA) <ul style="list-style-type: none"> – WA Health Medicines and Poisons Regulation Branch²⁰⁹ – Medicines and Poisons Act 2014²¹⁰ – Medicines and Poisons Regulations 2016²¹¹ |

| Guiding Principle | Relevant resources |
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| Guiding Principle 4 (continued) | <ul style="list-style-type: none"> ▶ Australian Government <ul style="list-style-type: none"> – Medicare Benefits Schedule (MBS)²¹² – Pharmaceutical Benefits Scheme (PBS)²¹³ – Translating and Interpreting Service (TIS)²¹⁴ ▶ Aged Care Quality and Safety Commission (ACQSC) Resource Library⁹⁵ ▶ Australian Government Department of Health Pharmacy Programs Administrator <ul style="list-style-type: none"> – Medication Management Programs¹⁹ including services provided by pharmacists to support the quality use of medicines and assist with minimising adverse medicines events – Medication Adherence Programs¹⁸ to improve medication adherence – Aboriginal and Torres Strait Islander Specific Programs²⁰ ▶ Australian Health Practitioners Regulation Agency (Ahpra) <ul style="list-style-type: none"> – Nursing and Midwifery Board: Decision-making framework for nurses and midwives Assessing the standards for practice for nurses and midwives²¹⁵ – Pharmacy Board of Australia Codes, Guidelines and Policies: Guidelines on practice-specific issues including a List of reference texts for pharmacists⁵⁸ ▶ Australian Nursing and Midwifery Federation (ANMF) <ul style="list-style-type: none"> – Professional Guidelines: Nursing Guidelines for Medicines Management in Aged Care²¹⁶ (under review) – Quality use of medicines position statement²¹⁷ – The use of dose administration aids by nurses and midwives position statement⁵⁹ – Care for people living with a disability position statement²¹⁸ ▶ Central Australian Rural Practitioners Association (CARPA)²¹⁹ Remote Primary Health Care Manuals⁸⁶ ▶ Edith Cowan University (Western Australia) Australian Indigenous HealthInfoNet²²⁰ ▶ Royal Pharmaceutical Society (UK) <ul style="list-style-type: none"> – MedicinesComplete²²¹ – a range of evidence-based medicine and healthcare information including complementary and herbal medicines, dietary supplements and interaction databases – Natural Supplements: An evidence-based guide. Fourth edition²²² – Herbal Medicines. Fourth edition²²³ ▶ EBSCO Information Services Natural & Alternative Treatments²²⁴ ▶ Therapeutic Research Centre Healthcare (TRC Healthcare) Natural Medicines²²⁵ <ul style="list-style-type: none"> – information on dietary supplements, natural medicines and complementation therapies ▶ Wolters Kluwer Lexicomp Drug Interactions²²⁶ – interaction database analysis tool, including facts and comparisons |

Guiding Principle Relevant resources

Guiding Principle 4 (continued)

- ▶ Medicine references – a minimum standard set of materials could include
 - [Australian Immunisation Handbook](#)²²⁷
 - [Australian Injectable Medicines Handbook](#)²²⁸
 - [Australian Medicines Handbook](#) (AMH)⁸⁰
 - [AMH Aged Care Companion](#)²²⁹
 - [AMH Children's Dosing Companion](#)²³⁰
 - Australian [Therapeutic Guidelines](#)²³¹
 - [MIMS](#)²³² and [AusDI](#)²³³ – Australian product information and CMI
 - [Micromedex](#)²³⁴ or [Stockley's Drug Interactions](#)²³⁵ – references on medicine interactions
 - [MedlinePlus](#)²³⁶ – references on complementary and alternative medicines
 - The Society of Hospital Pharmacists of Australia (SHPA) [Don't Rush to Crush](#)⁷⁸
 - [Australian Pharmaceutical Formulary](#) (APF)⁸¹
 - Wolters Kluwer [UpToDate](#)²³⁷
 - Cancer Institute NSW [eviQ](#)²³⁸
- ▶ Merck Sharp and Dohme: Free medical information
 - [Merck Manual \(Professional Version\)](#)²³⁹
 - [Merck Manual \(Consumer Version\)](#)²⁴⁰
- ▶ [NPS MedicineWise](#)¹²³
 - [Adverse Medicines Events Line](#)⁴³
 - [Australian Prescriber](#)²⁴¹
 - [Online learning module: Get it right! Taking a best possible medication history \(BPMH\) practice medication history](#)²⁴²
 - [Medicine Finder](#)²⁴³ – includes product information (PI)
 - [Professional education](#)²⁴⁴ – evidence-based education and professional development
 - [RADAR](#)²⁴⁵ timely, independent, evidence-based information on new drugs and medical tests and changes to listings on the PBS and MBS
- ▶ Queensland Health [Primary Clinical Care Manual \(PCCM\)](#)²⁴⁶
- ▶ National, state or territory information hubs
 - [Healthdirect](#)¹¹⁴
 - Victoria: [Better Health Channel](#)²⁴⁷
- ▶ Therapeutic Goods Administration (TGA)
 - [Adverse events reporting](#)²⁴⁸ for healthcare professionals to report any suspected adverse events to a prescription, complementary or non-prescription medicine or medical device
 - [Medicines safety updates](#)²⁴⁹ provides information and advice on medicine safety and emerging safety issues
 - [Reporting a problem of side effect about medicines or medical devices](#)⁴²
 - [Product information \(PI\)](#)²⁵⁰ provides a TGA-approved summary of the essential scientific information for the safe and effective use of a prescription medicine

| Guiding Principle | Relevant resources |
|---------------------------------|---|
| Guiding Principle 4 (continued) | <ul style="list-style-type: none"> ▶ Australian <i>Therapeutic Guidelines: Developmental disability</i>²⁵¹ ▶ University of NSW – Department of Developmental Disability Neuropsychiatry Responsible Psychotropic Prescribing to People with an Intellectual Disability Podcasts²⁵² have been developed for medical and mental health professionals including psychiatrists, paediatricians and mental health nurses ▶ Victorian Government Health Translations²⁵³ is an online library which enables health practitioners and those working with culturally and linguistically diverse communities to easily find free translated health information <p>To support the individual, their carer and/or family, and services</p> <ul style="list-style-type: none"> ▶ Aged Care Quality and Safety Commission (ACQSC) <ul style="list-style-type: none"> – Charter of Aged Care Rights⁸ protects the rights of consumers receiving Australian Government funded aged care services – Resource Library⁹⁵ ▶ Australian Commission on Safety and Quality in Health Care (ACSQHC) <ul style="list-style-type: none"> – Australian Charter of Healthcare Rights⁷ apply to all people in all places where health care is provided in Australia – Top Tips for Safer Health Care¹⁰³ to help individuals, their carers, families and other support people get the most out of their health care ▶ Australian Government Department of Health Poisons Information Centre⁴⁵ or call 13 11 26, for people who suspect an overdose or poisoning with a medicine(s) ▶ Australian Government Department of Social Services Carer Recognition Act 2010 Guidelines⁹ developed to increase recognition and awareness of the role carers play in providing daily care and support to people with disability, medical conditions, mental illness or who are frail aged ▶ Australian Government My Aged Care²⁵⁴ provides access for older Australians, their families, and carers to get the help and support they need from Australian Government-funded aged care services ▶ Australian Government Department of Veterans' Affairs (DVA) <ul style="list-style-type: none"> – Veterans' Medicines Advice and Therapeutic Education Services (Veterans' MATES)²⁵⁵ helpful resources for veterans and healthcare professionals – Health and medicine topics²⁵⁶ – Understanding your diuretic medicines²⁵⁷ – Tips for remembering your medicines²⁵⁸ – Therapeutic Brief – Staying healthy at home²⁵⁹ includes a guide to deprescribing in polypharmacy – Therapeutic Brief on preventing falls²⁶⁰ information on medicines that may contribute to falls and hip fractures in older people ▶ Better Health Channel Medicines information leaflets for consumers²⁶¹ |

Guiding Principle Relevant resources

- ▶ Choosing Wisely Australia
 - [Consumers and carers](#)¹¹⁹
 - [5 questions to ask your doctor or other healthcare provider before treatment](#)¹²⁰
 - [Communicating with your healthcare provider](#)²⁶²
 - [Toolkit: Patient and Public Engagement in Choosing Wisely](#)²⁶³
 - [Patient guide to managing pain and opioid medicines](#)²⁶⁴
 - [Starting a Choosing Wisely conversation](#)²⁶⁵
- ▶ Edith Cowan University (Western Australia) [Australian Indigenous HealthInfoNet](#)²⁶⁶
- ▶ [Healthdirect](#)¹¹⁴ provides a wide range of reliable information on medicines, health topics and wellbeing and [how to read CMI](#)s²⁶⁷
- ▶ National Aboriginal Community Controlled Health Organisation (NACCHO) [Medicines Management Network and Resources](#)¹²²
- ▶ [Medicines.org.au CMI search](#)²⁶⁸
- ▶ [NPS MedicineWise](#)¹²³
 - [Adverse Medicine Event \(AME\) Line](#)⁴³ or call 1300 134 237, for people to report and discuss adverse experiences with medicines
 - [Being medicinewise](#)²⁶⁹ – resources to help individuals, community groups and health services to promote being ‘medicinewise’
 - [Consumer medicine information \(CMI\) explained](#)²⁷⁰
 - [Finding good information about medicines](#)⁴⁸
 - [How a medicines review in your home can help you get the most from your medicines](#)²⁷¹
 - [Information for consumers and carers](#)²⁷²
 - [Managing your medicines](#)²⁷³
 - [Medicine Finder](#)²⁴³ – includes Consumer Medicines Information (CMI)
 - [Medicines Line](#)²⁷⁴ or call 1300 MEDICINE (1300 633 424), providing information on prescription, complementary and non-prescription (over-the-counter) medicines
 - [Medicines list](#)²⁷⁵ and [MedicineWise App](#)²⁷⁶ – to assist people to keep an up-to-date record of all medicines taken and is available in several languages
- ▶ Pharmacy Guild of Australia (PGA) [Consumer medicines information](#)²⁷⁷ – CMI Support materials for pharmacists
- ▶ Therapeutic Goods Administration (TGA)
 - [Consumer medicines information](#)²⁷⁸ an index of CMI searchable by medicine, trade name or active ingredient
 - [Reporting a problem of side effect about medicines or medical devices](#)⁴²

Guiding Principle Relevant resources

**Advocacy information**

- ▶ Aged Care Quality and Safety Commission (ACQSC) **Charter of Aged Care Rights**⁸
- ▶ Choosing Wisely Australia **Consumers and carers**¹¹⁹
- ▶ Older Persons Advocacy Network (OPAN) **Medication: It's your choice**²⁷⁹

Consumer medicines information (CMI)

- ▶ **Consumer medicines information**²⁷⁸ an index of CMI searchable by medicine, trade name or active ingredient
- ▶ Healthdirect **How to read CMIs**²⁶⁷
- ▶ Medicines.org.au. **CMI search**²⁶⁸
- ▶ NPS MedicineWise
 - **Medicine Finder**²⁴³
 - **Consumer medicine information (CMI) explained**²⁷⁰
- ▶ Pharmacy Guild of Australia (PGA) **Consumer medicines information**²⁷⁷ – CMI support materials for pharmacists
- ▶ Pharmaceutical Society of Australia (PSA) **Dispensing Practice Guidelines (2019)**²⁸⁰
- ▶ Victoria Better Health Channel **Medicines information leaflets for consumers**²⁶¹

Fact sheets and other resources on managing medicines

- ▶ Australian Government Department of Health and Aged Care
 - **Information for consumers**²⁸¹
 - **Health topics – Medicines**²
- ▶ Australian Government Department of Veterans' Affairs (DVA)
 - **Veterans' Medicines Advice and Therapeutic Education Services (Veterans' MATES)**²⁵⁵ helpful resources for veterans and healthcare professionals
 - **Health and medicine topics**²⁵⁶
 - **Therapeutic Brief – Staying health at home**²⁵⁹ includes a guide to deprescribing in polypharmacy
 - **Therapeutic Brief on preventing falls**²⁶⁰ information on medicines that may contribute to falls and hip fractures in older people
 - **Tips for remembering your medicines**²⁵⁸
 - **Understanding your diuretic medicines**²⁵⁷
- ▶ National Health and Medical Research Council (NHMRC) **Talking to patients about complementary medicine – a resource for clinicians**²⁸²
- ▶ NPS MedicineWise
 - **Keeping a medicines list**⁶⁴
 - **Managing your medicines**²⁷³
 - **Pill Reminder and Medication Reminder**²⁸³

| Guiding Principle | Relevant resources |
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| | <ul style="list-style-type: none"> ▶ NSW Government Families and Community Services <ul style="list-style-type: none"> – Medication Procedures²⁸⁴ – Medication Procedures tools and templates²⁸⁵ – Medication Procedures other resources²⁸⁶ – Medication Practice Manual²⁸⁷ <p>Managing acute illness</p> <ul style="list-style-type: none"> ▶ National Health Scheme (NHS) Scotland <ul style="list-style-type: none"> – Medicine Sick Day Rules card and resources²⁸⁸ – Medicines and Dehydration²⁸⁹ – patient information leaflet – Medicines and Dehydration²⁹⁰ – briefing for professionals on the Medicine Sick Day Rules card – Medicine Sick Day Rules card²⁹¹ – for patients outlining which medicines they should stop on ‘sick days’ and advice on when/how to restart the medicines once they are better |
|  <p>GUIDING PRINCIPLE 6</p> | <ul style="list-style-type: none"> ▶ Australian Government Pharmacy Programs Administrator Medication Adherence Programs <ul style="list-style-type: none"> – Dose Administration Aids²⁹³ – Indigenous Dose Administration Aids²⁹³ ▶ NPS MedicineWise <i>Australian Prescriber</i> Appropriate use of dose administration aids²⁹⁴ ▶ Pharmaceutical Society of Australia (PSA) <ul style="list-style-type: none"> – Guidelines for pharmacists providing dose administration aid services⁵⁵ Appendix 6 (2017) – Professional Practice Standards⁵⁷ Standard 15 (2017) ▶ Pharmacy Board of Australia (PBA) Guidelines on dose administration aids and staged supply of dispensed medicines (2015)⁵⁶ |
|  <p>GUIDING PRINCIPLE 7</p> | <ul style="list-style-type: none"> ▶ Aboriginal Indigenous HealthInfoNet Aboriginal and Torres Strait Islander Health Workers and Health Practitioners map of health/medical services²⁹⁵ – interactive map of Australia to search by state and territory ▶ Australian Government Australian Skills Quality Authority⁶⁰ ▶ Tasmania Disability Services Management Framework⁶² ▶ Victoria Pharmacotherapy treatment²⁹⁶ |
|  <p>GUIDING PRINCIPLE 8</p> | <ul style="list-style-type: none"> ▶ NPS MedicineWise <ul style="list-style-type: none"> – Keeping a medicines list⁶⁴ – Managing your medicines²⁷³ – MedicineWise app²⁷⁶ for smartphones – Medicines lists for Aboriginal and Torres Strait Islander people²⁹⁷ – Medicines lists in community languages²⁷⁵ to print off in English and 10 other languages – Pill Reminder and Medication Reminder: MedicineWise²⁸³ |

Guiding Principle Relevant resources

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- ▶ Australian Government Department of Health Pharmacy Programs Administrator
 - **Medication Management Programs**¹⁹ including services by pharmacists to support medication review in the home:
 - **Home Medicines Review (HMR)**⁷⁴
 - **MedsCheck and Diabetes MedsCheck**⁷⁵
 - **Aboriginal and Torres Strait Islander Specific Programs**²⁰
 - **Indigenous Health Service Pharmacy Support Program**²⁹⁸
- ▶ NPS MedicineWise **How a home medicines review in your home can help**²⁷¹
- ▶ Pharmaceutical Society of Australia (PSA)
 - **Guidelines for comprehensive medication management reviews**⁷⁶
 - **Guidelines for pharmacists providing MedsCheck and Diabetes MedsCheck**²⁹⁹
 - **Use of visual and audio technology in telehealth medication review consultations**³⁰⁰
 - **Telehealth Medication Review: Use of Digital Resources**³⁰¹
- ▶ Royal Australian College of General Practitioners (RACGP) **RACGP guidelines**¹⁷⁶

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Alteration of oral dose forms

- ▶ Australian Medicines Handbook (AMH) **AMH Drug Choice Companion: Aged Care**²²⁹
- ▶ Pharmaceutical Society of Australia (PSA) **Australian Pharmaceutical Formulary and Handbook**⁸¹
- ▶ The Society of Hospital Pharmacists of Australia (SHPA) **Don't Rush to Crush**⁷⁸

Assessment resources

- ▶ Speech Pathology Australia **Dysphagia Clinical Guideline (2012)**³⁰²
- ▶ International Dysphagia Diet Standardisation Initiative (IDDSI) **IDDSI Framework**³⁰³
 - describing food textures and drink thicknesses

Fact sheets and other resources on managing medicines

- ▶ National Disability Insurance Scheme (NDIS) Quality and Safeguards Commission
 - Practice alert: **Dysphagia, safe swallowing and mealtime management**⁷⁹
 - Practice alert: **Medicines associated with swallowing problems**³⁰⁴

Guiding Principle Relevant resources

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- ▶ Australian Government Department of Health and Aged Care [National Vaccine Storage Guidelines – Strive for 5](#)⁸²
- ▶ Pharmaceutical Society of Australia (PSA) [Guidelines for pharmacists providing dose administration aid services](#)³⁰⁵
- ▶ Diabetes NSW & ACT [Safe disposal of sharps](#)³⁰⁶
- ▶ [Return Unwanted Medicines \(RUM\) Project](#)⁸⁴ or call 1300 650 835 – [FAQs](#)³⁰⁷
- ▶ Therapeutic Goods Administration (TGA) [Product Information](#)²⁵⁰ which provides details of each medicine's storage requirements
- ▶ State and territory needle and syringe programs
 - [ACT](#)³⁰⁸
 - [NSW](#)³⁰⁹
 - [Northern Territory](#)³¹⁰
 - [Queensland](#)³¹¹
 - [South Australia](#)³¹²
 - [Tasmania](#)³¹³
 - [Victoria](#)³¹⁴
 - [Western Australia](#)³¹⁵

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- ▶ Australian Government Department of Health and Aged Care
 - [Australian Immunisation Handbook](#)²²⁷
 - [What is palliative care?](#)³¹⁶
- ▶ Australian Government Services Australia [Australian Immunisation Register for health professionals](#)⁹¹
- ▶ NPS MedicineWise [National Prescribing Competency Framework](#)³¹⁷
- ▶ NSW Health [End of life and palliative care medication prescribing](#)³¹⁸
- ▶ Safer Care Victoria [Anticipatory medicines](#)³¹⁹



Appendix: Background information

This Appendix contains background information on the importance of improving medication management in the community and updating these Guiding Principles. It includes details of:

- ▶ Emerging areas of importance in medication management
- ▶ Australia's Primary Health Care 10 Year Plan 2022–2032
- ▶ Communication and health literacy
- ▶ Digital health
- ▶ Non-medical prescribing or initiation of medicines
- ▶ Person-centred care
- ▶ Pharmacists
- ▶ QUM and medicines safety
- ▶ Rural practice
- ▶ Support and initiatives.

Emerging areas of importance in medication management

Research has shown that emerging areas of importance within the community setting include:

- ▶ Greater use of digital solutions for medication management
- ▶ New models of care – such as embedded pharmacists in general practice³²⁰
- ▶ The importance of deprescribing
- ▶ Polypharmacy and high-risk medicines – for instance, inappropriate psychotropic use in people with behavioural and psychological symptoms of dementia (BPSD)

- ▶ Transitions of care and continuity issues – for instance
 - entry to aged care from the community
 - transition from hospital back to the community
 - transition of care between GPs and specialists
- ▶ Non-medical initiation of medicines (prescription and non-prescription)
- ▶ Greater use and reliance on dose administration aids (DAAs)
- ▶ **National Aged Care Mandatory Quality Indicators**³²¹ (QI Program)
- ▶ **Serious Incident Response Scheme (SIRS)**.⁴¹

Australia's Primary Health Care 10 Year Plan 2022–2032

In March 2022, the Australian Government Department of Health published **Australia's Primary Health Care 10 Year Plan 2022–2032**.³²² The plan:

- ▶ Provides a useful delineation between 'primary health care' and 'primary care'
- ▶ Acknowledges and recognises the challenge people face when navigating the health system and the inoperability of digital health systems
- ▶ Signals growing direction towards collaborative commissioning between Primary Health Networks and Local Hospital Networks under the National Health Reform Agreement to deliver more integrated, value-based care pathways at local and regional level
- ▶ Signals the Australian Government's intention to implement the recommendations from the review into general practice accreditation.

Communication and health literacy

Literacy and language barriers contribute to poor communication. Along with the need for effective communication, a person's level of health literacy (including digital health literacy) is recognised as an important factor in improving safety and quality of medication management.³²³

Access to information resources is an important part of medication management. The information also needs to consider those from a culturally and linguistically diverse (CALD) background including Aboriginal and Torres Strait Islander peoples. Multimedia and multi-lingual resources should be sourced and used to cater the needs of target groups of people – for example, people with disability and CALD communities.

Digital health

Use of digital health solutions like My Health Record, electronic prescribing and electronic medication management has increased significantly since the 2006 edition of these Guiding Principles was published.³²⁴ Digital tools for medication management are associated with improved documentation and completeness of medicines lists and prescriptions, and reduced use of inappropriate medicines.

Non-medical prescribing or initiation of medicines

Non-medical prescribing is not a new concept in Australia as optometrists, podiatrists and nurse practitioners have been authorised to prescribe under various state legislation for some time. Eligible midwives also have prescribing rights nationally.³²⁵ The **Health Professionals Prescribing Pathway (HPPP)**³²⁶ was developed as a nationally recognised approach to the prescribing of medicines by health professionals (other than medical practitioners) registered under the National Registration and Accreditation Scheme. Nurse practitioners have an increasing role in aged care. In aged care settings, nurse practitioners can prescribe medicines within their scope of practice and provide support and direction to registered nurses and enrolled nurses in managing the complex care needs of people with chronic disease.

Person-centred care

A person-centred approach necessitates a greater focus on people with specific needs. This includes older people in residential aged care; Aboriginal and Torres Strait Islander peoples; people from culturally and linguistically diverse backgrounds (including migrants and refugees); people with mental illness, disability or chronic conditions; those living in rural and remote areas and other vulnerable groups.³ It calls for, for example, greater emphasis on cultural safety in providing medication management services to Aboriginal and Torres Strait Islander peoples.

Pharmacists

Pharmacy services within the community continue to develop. For over 20 years, the Australian Government has funded medication reviews by pharmacists, and continues to do so under the **7th Community Pharmacy Agreement (7CPA)**.³²⁷ The current program rules³²⁸ fund collaborative Home Medicines Reviews (HMR), MedsChecks and Diabetes MedsChecks. The 7CPA also supports additional services and activities by pharmacists – for instance, Residential Medication Management Reviews (RMMRs), aimed at supporting QUM and medication safety within residential aged care facilities (RACFs).

The **Quality Care Pharmacy Program (QCPP)**¹⁷⁴ is an accreditation program specifically available for pharmacies. Other services provided by community pharmacy, include vaccinations, the National Diabetes Supply Scheme (NDSS) and some state based (and funded) services.

QUM and medicines safety

Australian research has shown that more than 250,000 hospital admissions each year are due to harm from medicines and half of them could be prevented with better medication management. The **Medication without harm – WHO Global Patient Safety Challenge**³²⁹ aims to halve preventable medication related harm by 2023. Australia's response⁷³ has similar objectives including the goal to reduce avoidable medication errors, reduce adverse drug events and halve medicines-related hospital admissions by 2025. These objectives align with the intent of Australia's 10th National Health Priority: Quality Use of Medicines and Medicines Safety.³³⁰

Governance of medication management in the community relies upon each healthcare professional and community healthcare service providers respectively taking personal responsibility and having systems in place that meet national, state or territory legislative requirements and result in a safe system for medication management in the community.

Rural practice

Rural and remote areas face additional barriers in access to both GPs and pharmacists. Rural GPs workload and time constraints make it difficult to spend time away from in practice work to service aged care facilities.³³¹ By 2027, without intervention, it is estimated there will be as few as 52 pharmacists per 100,000 people in regional and remote areas, compared to 113 pharmacists per 100,000 people in major cities.³³²

Support and initiatives

Primary Health Networks and Local Health Networks 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 benefits of **My Health Record**³³³ to assist secure, electronic sharing of information on an individual's health care, including medicines information, is being realised following incentive programs for GPs and pharmacists.

Other national initiatives include:

- ▶ The **Medication safety**³³⁴ program of the Australian Commission on Safety and Quality in Health Care (the Commission) – including the **National Residential Medication Chart (NRM)**³³⁵ and **electronic NRM**³³⁶
- ▶ The Commission's **Australian Atlas of Healthcare Variation Series**³³⁷, and **Antimicrobial Stewardship in Aged Care**³³⁸ resources
- ▶ Prescriber and community information and education programs through **NPS MedicineWise**¹²³
- ▶ The national recognition of health professionals through the **Australian Health Practitioner Regulation Agency (Ahpra)**¹⁶⁹
- ▶ Pharmaceutical Society of Australia **Guidelines for Clinical Governance in pharmacy services**¹⁴⁷
- ▶ Pharmacy Guild of Australia **Quality Care 2020 Framework**³³⁹ and **Quality Care Community Pharmacy Program and Standard**¹⁷ – AS85000:2017
- ▶ Australian Digital Health Agency (ADHA) **My Health Record**³³³ resources for **people and their families**³⁴⁰ and **healthcare professionals**.³⁴¹



Acronyms and abbreviations

| | | | |
|---------------|--|--------------|---|
| 7CPA | 7th Community Pharmacy Agreement | CMI | consumer medicines information |
| ACQSC | Aged Care Quality and Safety Commission | CQI | continuous quality improvement |
| ACSQHC | Australian Commission on Safety and Quality in Health Care | DAA | dose administration aid |
| ACT | Australian Capital Territory | DVA | Department of Veterans' Affairs |
| ACTS | Aged Care Transfer Summary | EN | enrolled nurse |
| Ahpra | Australian Health Practitioner Regulation Authority | eNRMC | electronic National Residential Medication Chart |
| AHRQ | Agency for Health Research and Quality | GP | general practitioner |
| AIR | Australian Immunisation Register | HACC | home and community care |
| AMA | Australian Medical Association | HMR | Home Medicines Review |
| AME | Adverse Medicine Event (Line) | IDDSI | International Dysphagia Diet Standardisation Initiative |
| AMH | <i>Australian Medicines Handbook</i> | IHI | Institute for Healthcare Improvement |
| ANMF | Australian Nursing and Midwifery Federation | MAC | medication advisory committee |
| APF | Australian Pharmaceutical Formulary | MMP | medication management plan |
| BPMH | best possible medication history | NDIS | National Disability Insurance Scheme |
| BPSD | behavioural and psychological symptoms of dementia | NDSS | National Diabetes Supply Scheme |
| CAL | cautionary advisory label | NHMRC | National Health and Medical Research Council |
| CALD | culturally and linguistically diverse | NIM | nurse-initiated medicine |
| CDM | chronic disease management | NMBA | Nursing and Midwifery Board of Australia |
| CEC | Clinical Excellence Commission | NMP | National Medicines Policy |
| | | NP | nurse practitioner |

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| NPS | National Prescribing Service |
| NRMC | National Residential Medication Chart |
| NSQHS | National Safety and Quality Health Services |
| NSW | New South Wales |
| NT | Northern Territory |
| OPAN | Older Persons Advocacy Network |
| OTC | over-the-counter |
| PBA | Pharmacy Board of Australia |
| PBS | Pharmaceutical Benefits Scheme |
| PDSA | Plan-Do-Study-Act |
| PGA | Pharmacy Guild of Australia |
| PHN | Primary Health Network |
| PI | product information |
| PRN | <i>pro re nata</i> (when required or if necessary) |
| PSA | Pharmaceutical Society of Australia |
| QCPP | Quality Care Pharmacy Program |

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|---------------|---|
| QUM | quality use of medicines |
| RACF | residential aged care facility |
| RACGP | Royal Australian College of General Practitioners |
| RANZCP | The Royal Australian and New Zealand College of Psychiatrists |
| RCA | root cause analysis |
| RUM | Return Unwanted Medicines |
| SA | South Australia |
| SHPA | The Society of Hospital Pharmacists of Australia |
| SIRS | Serious Incident Response Scheme |
| SUSMP | Standard Uniform Scheduling of Medicines and Poisons |
| TAG | Therapeutic Advisory Group |
| TGA | Therapeutic Goods Administration |
| UK | United Kingdom |
| WHO | World Health Organization |

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