Australian Government
Department of Health and Aged Care

Medication management in residential aged care facilities

GUIDING PRINCIPLES

National quality use of medicines

Contents

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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 within a RACF.

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 residential aged care service providers.

The Guiding Principles are based on current best practice and available evidence and are intended to be applicable to all RACF settings and the people receiving care within RACFs. Their application must consider relevant national, state and territory legislative requirements, profession-specific licensing/registration, codes of practice, guidelines and standards, and aged care quality and accreditation standards and requirements.

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- Austin Health Pharmacy Department
- Australian College of Nursing
- Australian Commission on Safety and Quality in Health Care
- Australian Digital Health Agency
- Australian Medical Association
- Australian Nursing and Midwifery Federation
- Australian Primary Health Care Nurses Association
- Berowra Family Medical Practice
- Bolton Clarke
- Carers NSW
- Children's Health Queensland Hospital and Health Service
- Crowley Care
- Council of the Ageing (COTA) Australia
- Department of Health, Tasmania
- Department of Health, Western Australia
- Goodwin Aged Care Services
- Gowan and Associates
- InterHealth Medical Clinic
- Leading Aged Services Australia
- Leichhardt General Practice
- Life Care
- May Shaw Health and Wellbeing Facilities
- Melbourne City Mission
- National Aboriginal Community Controlled Health Organisation (NACCHO)
- National Prescribing Service (NPS MedicineWise)
- National Disability Insurance Scheme (NDIS) Quality and Safeguards Commission
- NSW Clinical Excellence Commission
- NSW Ministry of Health
- NSW Nurses and Midwives' Association
- Occupational Therapy Australia
- Pharmaceutical Defence Limited
- Pharmaceutical Society of Australia
- Pharmacy Board of Australia
- Pharmacy Guild of Australia
- Pharmeducation
- Princess Alexandra Hospital
- Queensland Health
- Queensland Nurses' & Midwives Union
- Resthaven Incorporate
- Returned Services League (RSL) LifeCare
- Royal Australian College of General Practitioners
- Royal Flying Doctors Service
- Royal Prince Alfred Hospital

- Sir Charles Gairdner Hospital
- Society of Hospital Pharmacists of Australia
- South Australia Health
- St Vincent's Hospital Melbourne
- Sunshine Coast Hospital and Health Service
- University of South Australia
- University of Sydney
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Introduction

Guiding Principles

These *Guiding Principles for Medication Management in Residential Aged Care Facilities* (2022 Ed.) build upon on the previous edition published in 2012 and promote practice that keeps the individual receiving care at the centre of an integrated health system. It also has a 'supplement' *User Guide: Role of a Medication Advisory Committee*.

Related publications

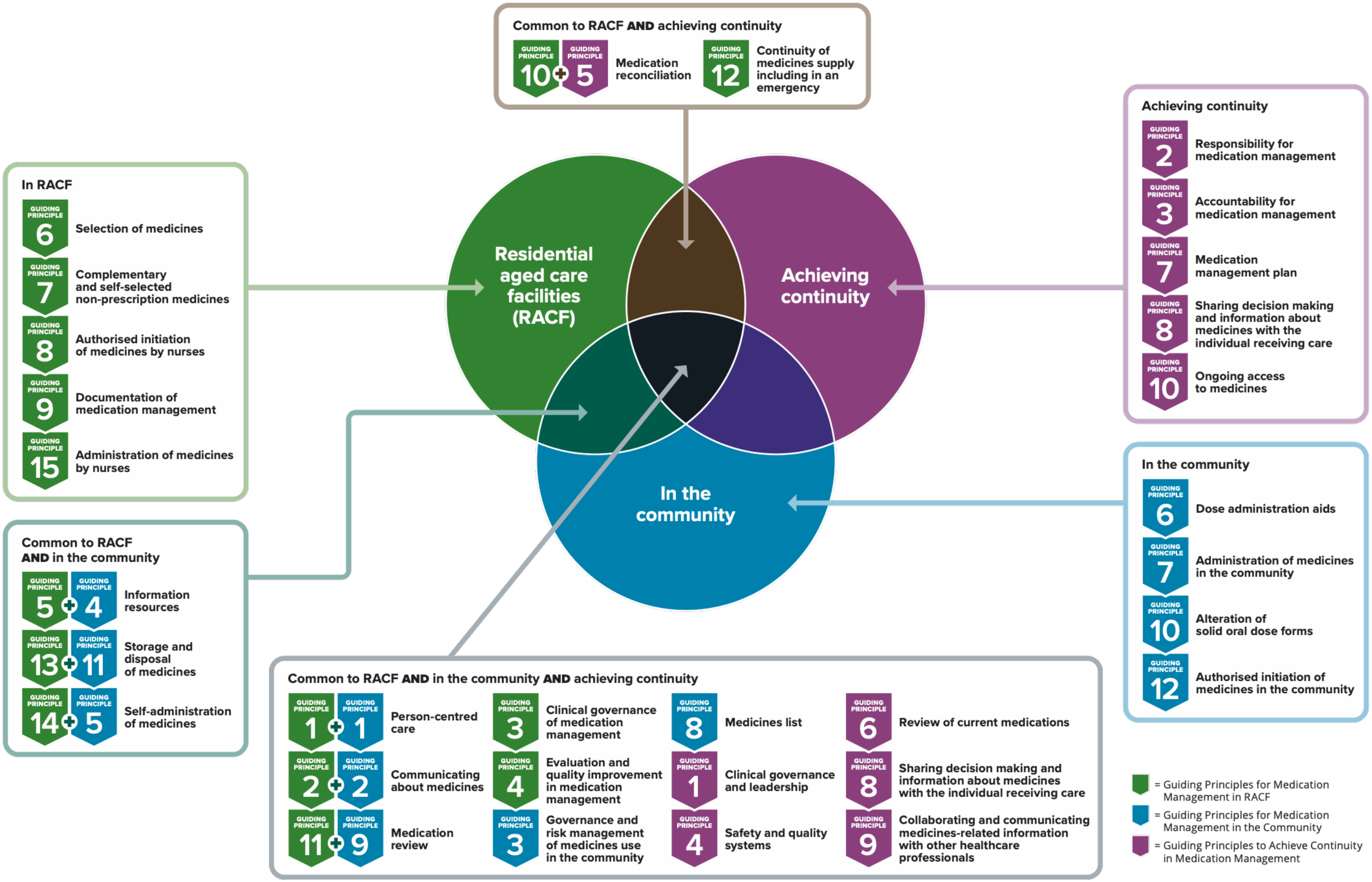
Users of *Guiding Principles for Medication Management in Residential Aged Care Facilities* should be aware of these other closely related publications, and refer to them as needed:

- The 'supplement' User Guide: Role of a Medication Advisory Committee
- *Guiding Principles to Achieve Continuity in Medication Management*
- *Guiding Principles for Medication Management in the Community*
- *Glossary for the Guiding Principles and User Guide*.

Figure 1 outlines the relationship between the 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

Most people in residential aged care facilities (RACFs) need to take medicines, and many take a number of different medicines for different health conditions.

The term ‘medicine’ covers a broad range of products that are used to prevent, treat, monitor, or cure a disease.[1] This includes, but is not limited to, prescription, complementary and non-prescription medicines.

RACFs must support and often manage the medicines needs of each person in care, while ensuring safe and quality medication management, including for those moving between the RACF and other care settings or aged care service providers.

These *Guiding Principles for Medication Management in Residential Aged Care Facilities* (the Guiding Principles) build on the previous 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 medicinesrelated services to be accessible in an equitable, safe, timely, and affordable way’.[2] 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 personcentred approach for medication management within RACFs 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.[2]

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 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 RACFs. They are intended to assist RACFs to:

- Establish and implement formalised medicines governance arrangements
- Develop, implement, and evaluate – locally – specific policies, procedures and guidelines
- Support those involved in assisting care recipients
- Support people receiving care in the medication management process.

In addition, users should refer to the *User Guide: Role of a Medication Advisory Committee*. This is a ‘supplement’ to the *Guiding Principles for Medication Management in Residential Aged Care Facilities*.

The Guiding Principles and ‘supplement’ are intended for use by all QUM partners, including government, healthcare professionals and providers, the individual, their carer and/or family, and others.

The Guiding Principles advocate a person-centred partnership and systems approach to achieve safe and quality use of medicines and medication management within RACFs. Sound governance of medication management is fundamental.

Development of the Guiding Principles

This document is a revision of the *Guiding Principles for Medication Management in Residential Aged Care Facilities* published by the (former) Australian Government Department of Health in October 2012.

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

The review process involved:

- Engaging the University of South Australia (UniSA) to undertake analysis of relevant documents and published literature
- Identifying current best-practice evidence and areas of importance in QUM and medication management within RACFs
- Public consultation with over 80 peak organisations, and experts, involved in medication management in RACFs
- Analysis of relevant documents and published literature
- Targeted consultations with consumers and those working or providing care within RACFs 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 residential aged care sector in medicines use and medication management since the 2012 edition of the Guiding Principles. At that time, a higher proportion of people would have lived in RACFs. Evidence shows that:

- 98% of aged care recipients have at least one medicines-related problem
- Over half are exposed to at least one potentially inappropriate medicine
- Approximately 17% of unplanned hospital admissions by people living in RACFs are caused by an inappropriate medicine.[3]

Further:

- Up to 91% of people in Australian RACFs are prescribed more than five concomitant medicines, and up to 74% of care recipients take more than nine medicines[4]
- Prevalence of Poly-pharmacy 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]
- In 2017–18, one in two Australians had one or more of 10 recognised chronic conditions and one in five had two or more of these chronic conditions.[6] Given Australia's burden of disease[7], the medication management needs of people living in RACFs are now more complex than they were in 2012
- At some point during 2019–20, around 245,000 people were living in permanent residential aged care[8], 54% of whom had dementia (about 132,000 people)[9] – a formal diagnosis of dementia rather than cognitive decline. Respite residential aged care accounted for around an additional 67,000 people[9]
- The healthcare environment is also changing, and people are living in their homes for longer[10]; this delayed entry to residential aged care means that people will be older, more frail and sicker when they do enter a RACF[8]
- The Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers: First Results (2015)[11], found that nearly all people living in RACFs in 2015 had some type of disability (96.5%)
- In 2015, most people living in RACFs with a disability had a physical restriction (88.5%), such as chronic pain or incomplete use of arms or legs, with many also having a psychosocial restriction (73.1%), including memory problems and social or behavioural difficulties; both physical and psychosocial restrictions impact an aged care recipient's ability to self-administer their medicines.[11]

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

- Emerging challenges during transitions of care
- Aged Care Quality Standards
- Communication and health literacy
- Person-centred care
- QUM and medicines safety
- Royal Commission into Aged Care Quality and Safety
- Support and Initiatives
- Transitions of care
- Workforce.

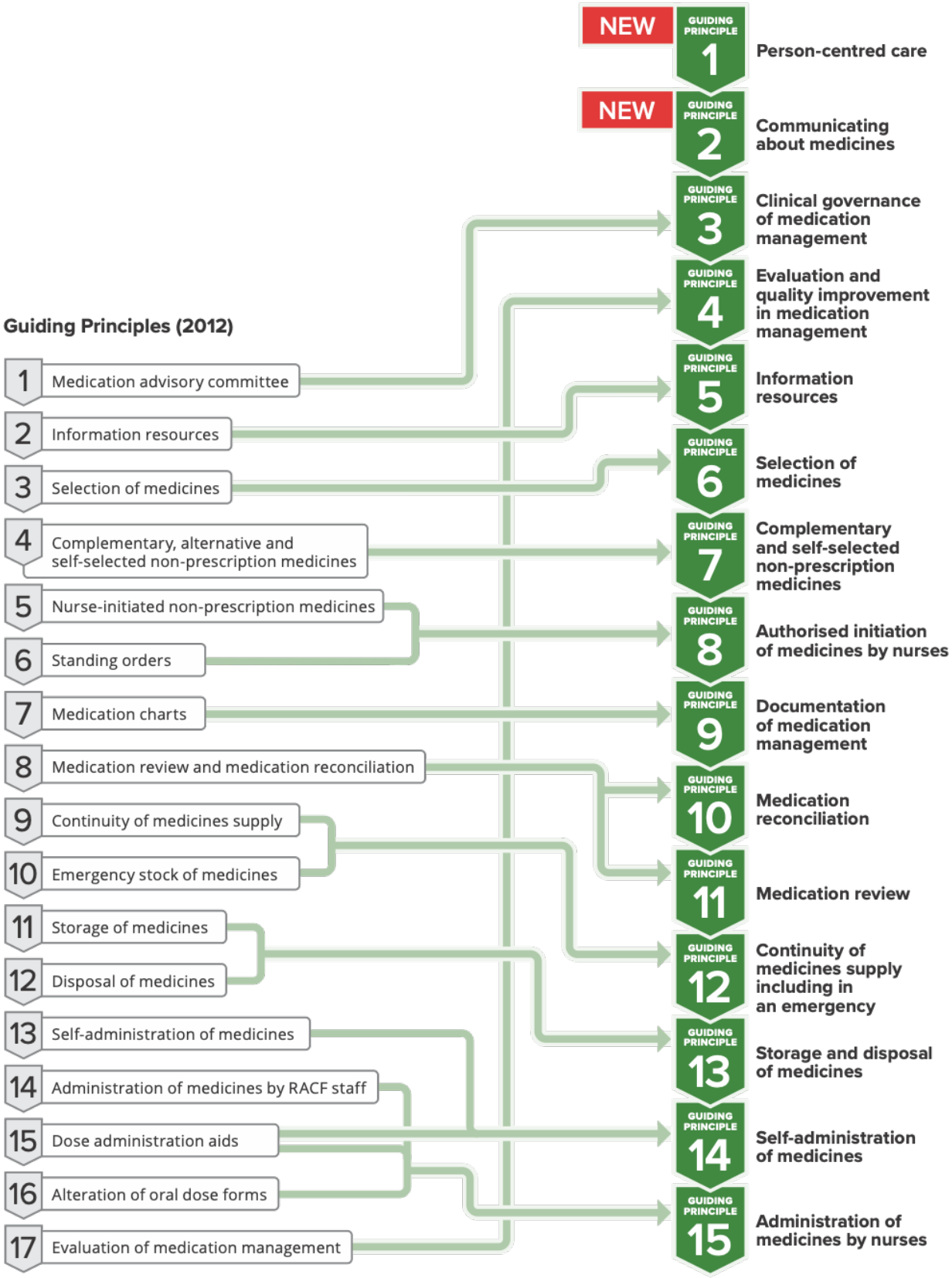
The importance of improving medication management and information with the Appendix: Background information, along with the review process, has informed the content for these Guiding Principles (2022 Ed.). The result is a new numbering, naming and configuration to a total of 15 Guiding Principles, including two new overarching Guiding

Principles, and accompanied by a supplement – *User Guide: Role of a Medication Advisory Committee*. The mapping of the revised Guiding Principles is illustrated in Figure 2 on the next page.

Summary of changes

Figure 2: Mapping 2012 edition to 2022 edition of the Guiding Principles

This figure illustrates the mapping of the 2012 edition to the 2022 edition of the Guiding Principles.



How to use the Guiding Principles

Each of the 15 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 RACF, the healthcare workforce, 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 1–4 set the overarching requirements for the effective implementation of the remaining Guiding Principles 5–15.

Each Guiding Principle should be read in conjunction with corresponding information which includes further explanation of each Guiding Principle and information, such as key tasks and strategies to support its implementation.

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

- **The residential aged care facility** (RACF) – A special-purpose facility that provides accommodation and personal care 24 hours a day, as well as access to nursing and general healthcare services, along with support and assistance towards independent living, for senior Australians who can no longer live in their own home. A RACF's Board of Management (or governing body) is accountable for the delivery of safe and quality care and services.
- **The healthcare workforce** – Includes trained healthcare professionals who provide direct clinical care to individuals – for instance, doctors, nurses (including enrolled nurses), pharmacists, care workers (however titled), optometrists, physiotherapists, podiatrists and other allied health professionals. Healthcare professionals may provide care within a RACF as an employee, a contractor or a credentialed/accredited healthcare provider, or under other working or service arrangements.
- **The individual, their carer and/or family** – An individual who has used, or may potentially use, healthcare services, or their carer and/or family member for an individual receiving care within a RACF. Depending upon the individual's circumstances this will also include substitute decision-makers.

Roles and responsibilities in medication management

Aged care in Australia includes supports with everyday living, health care, accommodation and equipment for older people in their own home, in the community, or in a residential aged care setting. In 2022, the *Aged Care Act 1997* is still the main law that covers Australian government-funded aged care. It sets out rules for items like funding, regulation, approval of providers, quality of care and the rights of people receiving care. Laws on diversity and discrimination also apply to aged care. Aged care programs funded by the Australian Government include residential aged care and respite care.

The Australian Government has commenced reforms to residential aged care, including changes to funding[12] and legislation.[13] In its 2021–22 Budget, the Australian Government committed to align the different regulations of Australian Governmentfunded care and support to make it easier for care to be delivered and supported, and ensure consistent quality and safety across the regulated sectors. This commitment was in addition to a range of comprehensive reforms to aged care.[14]

Approved residential aged care providers have obligations and responsibilities described in the Aged Care Quality Standards[15] and are regulated by the Australian Government Department of Health and Aged Care and the Aged Care Quality and Safety Commission. Medication management forms part of the care provided under the Act and Standards.

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

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

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

In some jurisdictions, assistants in nursing 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, regulation and RACF policies and procedures for delegation and supervision. While some may have vocational training in medicines-related tasks, these staff are not bound by professional practice standards and guidelines set by a licensing authority.

Individuals receiving care within RACFs and their carers have both rights and responsibilities in health care, as described in the Australian Charter of Healthcare Rights[17], the Charter of Aged Care Rights[18] and the *Carer Recognition Act 2010*[19]. 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 is seen as part of the healthcare functions and services covered by the above-mentioned charters. Aged care recipients also have specific rights in medication management, including the right to choose and appoint their own general practitioner (GP) and pharmacist.

In addition, consumer protections such as the *Privacy Act 1988*[20] and associated Privacy Principles[21] 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 member of the healthcare workforce can actively contribute and participate. An interdisciplinary teambased approach to medication management is fundamental to ensuring QUM and medicines safety within residential aged care.

The Guiding Principles

Guiding Principle 1: Person-centred care

The RACF provides 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.

Guiding Principle 2: Communicating about medicines

The RACF ensures that all medicines-related communications consider health literacy, are 'person-centred', and collaborative, and facilitate shared decisionmaking, advocacy and selfdetermination.

Guiding Principle 3: Clinical governance of medication management

The RACF has systems and processes that are used to support and promote safe and effective management of the quality use of medicines within the facility.

Guiding Principle 4: Evaluation and quality improvement in medication management

The RACF routinely reports on the mandatory medication management indicators and regularly reviews, identifies and evaluates risk within each area of medication management, taking follow-up action where required.

Guiding Principle 5: Information resources

The RACF ensures access to the most current and evidence-based medicinesrelated information, tools and resources for each person receiving care, their carers, the RACF healthcare team and visiting healthcare providers.

Guiding Principle 6: Selection of medicines

The RACF supports informed evidence-based decision-making for the selection of medicines used within the facility.

Guiding Principle 7: Complementary and self-selected non-prescription medicines

The RACF supports informed selection and safe use of complementary and self-selected non-prescription medicines for each person receiving care.

Guiding Principle 8: Authorised initiation of medicines by nurses

Where deemed appropriate, the RACF has policies, procedures and guidelines, endorsed by the RACF's MAC, in place to allow the authorised:

- Initiation of non-prescription medicines from an approved list
- Use and review of prescription medicine treatment protocols.

Guiding Principle 9: Documentation of medication management

To support safe prescribing, dispensing and administration of each person's medicines and effective communication of their medicines-related information, the RACF ensures that a current, accurate and reliable record of all medicines selected, prescribed and used is documented on their medication chart (paperbased or electronic).

Guiding Principle 10: Medication reconciliation

Medication reconciliation processes are used within RACFs to:

- Verify a person's medication history
- Reduce the risk of errors in medicines documentation when care is transferred, or new medicines are prescribed
- Ensure all medicines are ordered and received as intended.

Guiding Principle 11: Medication review

The RACF healthcare team and visiting healthcare providers ensure that each person's medicines are reviewed regularly and as needed, to optimise medicines use and minimise medicines-related problems.

Guiding Principle 12: Continuity of medicine supply including in an emergency

The RACF minimises interruptions to medicines supply and maintains timely access to medicines for each person receiving care. This may include having access to a curated emergency stock of medicines.

Guiding Principle 13: Storage and disposal of medicines

The RACF ensures that:

- All medicines, including self-administered medicines, are stored and handled safely and securely, and in a manner that maintains the quality of the medicines
- Unwanted, ceased or expired medicines are disposed of safely to avoid accidental harm and misuse
- Disposal of medicines aligns with sustainable and environmental best practice.

Guiding Principle 14: Self-administration of medicines

The RACF:

- Supports and seeks informed consent from individuals who wish to administer their own medicines

- Ensures policies, procedures and guidelines are in place to guide the assessment and re-assessment of a person's capacity to self-administer medicines safely.

Guiding Principle 15: Administration of medicines by nurses

Each RACF ensures it has policies, procedures and guidelines in place that are endorsed by the RACF's MAC, to guide the safe and effective administration of medicines by appropriately qualified and authorised nurses.

Guiding Principle 1: Person-centred care

The RACF provides 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

Each person receiving care in a residential aged care facility (RACF) has the right to make choices and decisions about their own care.

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 individual receiving care (including their carer, family and/or substitute decision-maker) within residential aged care is:

- Asked about their medicine needs, preferences and medicine-taking behaviours, including prescription, complementary and nonprescription 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
- Individually 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 the people around them
- Encouraged and supported to give feedback about their medication management – for instance, adverse reactions or complaints about their medicines.

Carers, family and/or the 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.

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.

Implementation – key tasks and strategies

This Guiding Principle is applied across the *Guiding Principles for Medication Management in Residential Aged Care Facilities*.

Resources

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

Reflective questions

- How does the RACF 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 an individual receiving care and their carers?
- How is medicines-related information tailored to the individual's specific needs?
- How is a person receiving care involved in the decision-making and consent processes, about the medicines that are being prescribed or administered?
  - How are carers, family and/or substitute decision-makers included in the decision-making about an individual's treatment options and choices?
- What are the processes for ensuring a person's rights with respect to medicines, including self-selected complementary and non-prescription medicines?

Further questions

In addition to the questions listed above, also refer to:

- The series of ‘Reflective questions’ included within each Guiding Principle
- Relevant reflective questions included within the following Aged Care Quality Standards
  - Standard 1: Consumer dignity and choice[22]
  - Standard 2: Ongoing assessment and planning with consumers[23]
  - Standard 6: Feedback and complaints.[24]

GUIDING PRINCIPLE 2

Guiding Principle 2: Communicating about medicines

The RACF ensures that 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 carers, family and/or substitute decision-maker) is:

- Person-centred, respectful and tailored to their health literacy (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 combination, supports the continuity of medicines supply (refer to Guiding Principle 9: Documentation of medication management).

RACFs should set up and maintain systems and processes to support effective communication:

- With the individual receiving care, their carer, family and/or substitute decision-maker
- With and between healthcare professionals, including visiting healthcare providers, pharmacy and other service providers
- Across the group of residential aged care service providers (if relevant).

The RACF workforce uses these systems and processes to communicate effectively and collaboratively 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 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 a person is 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
- Documentation of changes in a person's health status and/or to their medicines (refer to Guiding Principle 9: Documentation of medication management)
- The individual receiving care 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: Clinical governance of medication management and Guiding Principle 4: Evaluation and quality improvement in medication management).

Implementation – key tasks and strategies

This Guiding Principle is applied across the *Guiding Principles for Medication Management in Residential Aged Care Facilities*.

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 visiting healthcare providers, pharmacy and other service providers use to effectively communicate with an individual receiving care (along with their carer, family and person responsible) about their 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 RACF collect and use feedback (including complaints) to improve communication about medicines?

Further questions

In addition to the questions listed above, also refer to:

- The series of 'Reflective questions' included within each Guiding Principle
- Relevant reflective questions included within the following Aged Care Quality Standards[15]:
- Standard 1: Consumer dignity and choice[22]
- Standard 2: Ongoing assessment and planning with consumers[23]
- Standard 6: Feedback and complaints.[24]

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*[359] 'Medication Safety Standard'.

GUIDING PRINCIPLE 3

Guiding Principle 3: Clinical governance of medication management

The RACF has systems and processes in place that are used to support and promote the safe and effective management of medicines within the facility.

Summary and intent

Medication management in a residential aged care facility (RACF) operates within a clinical governance framework. It ensures that the rights and responsibilities of each individual receiving care, their carer, family and/or substitute decision-makers, are taken into account.

A medicines governance group – for example, a medication advisory committee (MAC) or equivalent – needs to be established and recognised within the RACF's committee structure.

The medicines governance group is a multidisciplinary committee that provides expert advice and overarching governance of medication management in a RACF to ensure the judicious, appropriate, safe, and quality use of medicines.[25]

The RACF's Board of Management and Executive holds the responsibility to establish and use (or have direct access to) a medicines governance group to assist and advise in the development, endorsement, promotion, monitoring, review and evaluation of medication management policies, procedures and guidelines.

The medicines governance group also has a role in:

- Providing advice on legislation, standards and processes
- Advising on risk-management systems associated with medication management to
- report and analyse medicines-related mandatory quality indicators
- evaluate other relevant indicators (including incidents, adverse medicine events and complaints)
- Identifying education and training needs for medication management
- Monitoring the effectiveness and performance of medication management, as well as implement quality improvement strategies for this (refer to Guiding Principle 4: Evaluation and quality improvement in medication management).

The RACF's safety and quality systems and processes for medication management:

- Support prescribers, nurses and care staff in the safe and effective use of medicines
- Reduce medicines-related risk.

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

The Australian Commission on Safety and Quality in Health Care's National Model Clinical Governance Framework[26] provides a consistent national framework for clinical governance. The *Clinical Governance Principles for Pharmacy Services*[27] recognises and has contextualised this approach to clinical governance within pharmacist-led services.

Most community pharmacies in Australia are accredited against AS85000 Quality Care Pharmacy Program (QCPP) Standard[28] which contains some elements of clinical governance, including risk management and staff management. Accreditation is a requirement to be eligible for community pharmacies to receive payments for services included under the Pharmacy Programs Administrator – for instance, medication adherence[29], medication management[30] and Aboriginal and Torres Strait Islander specific programs.[31]

In aged care clinical governance means an integrated set of leadership behaviours, policies, procedures, responsibilities, relationships, planning, monitoring and improvement mechanisms that are implemented to support good clinical care and good outcomes for each aged care recipient.

Residential aged care providers have obligations and responsibilities, as described in the Aged Care Quality Standards. Standard 8: Organisational Governance.[32] This describes the requirements for RACFs to have effective organisation-wide governance and risk-management systems that support delivery of safe and quality care and services.

Medicines governance must align within the overall governance structure of the RACF. This includes having a formalised structure that includes a medicines governance group articulated within the organisation's governance framework and/or organisational chart.

The governance framework needs to outline the reporting relationships of the medicines governance group. Typically, this will be a direct reporting relationship to the RACF's Executive.

For instance, the RACF's Board of Management and/or Executive, may refer issues either directly or via the RACF's Executive to its committees – for example, audit and risk committee, remuneration committee, investment committee, governance committee. This would include a medicines governance group working with the RACF's Executive to oversee the organisation-wide safe and quality use of medicines.

The implementation of an effective clinical governance model can help by:

- Ensuring a systematic overview of all aspects of medication management within the RACF
- Ensuring that the rights, including informed consent and privacy, of people receiving care, are taken into account in medication management policy and practice
- Identifying best-practice models of care or service delivery that promote individual and organisational accountability for achieving healthcare outcomes
- Management recording and analysing of medication management data, as required by the National Aged Care Mandatory Quality Indicator Program[33], to compare professional service provision against the required indicators and defined health outcomes.

Medicines governance group

Most RACFs are likely to have, or have access to, a medicines governance group – referred to as a 'medication advisory committee' or 'MAC'.

The MAC's position within the organisational structure needs to enable the assignment of responsibility for implementing quality improvement initiatives through the appropriate organisational and management pathways. The responsibility for implementing and monitoring the decisions of the MAC needs to be clearly defined – for example, in the MAC's

terms of reference (ToR). However, implementation remains the responsibility of the organisation's Executive management or is delegated to a pharmacist – for example, the Quality Use of Medicines (QUM) Registered or Accredited Pharmacist.[34]

Approved by the RACF's Board of Management, the MAC's ToR needs to describe the formal links to the RACF's governance, management and continuing quality assurance structures and processes.

The composition of the MAC needs to be multidisciplinary and, in addition to senior residential care staff, should include at least one or more of the following:

1. **General practitioner** (GP)
2. **Nurse practitioner** (NP)
3. **Pharmacist***
4. **Registered nurse** involved in direct care of an individual
5. **Care recipient or advocate** (for example, a carer) or representative for people receiving care
6. **Administrator/secretariat** to support the function of the MAC.

At a minimum, the roles outlined above should be included with membership that:

- Reflects the size of the organisation (provider and/or facility) and the services provided
- Represents all stakeholders' views in medication management.

A MAC:

- Provides a multidisciplinary partnership approach to medication management
- Supports evidence-based practice
- Provides a forum in which to raise policy and practice issues
- Enables and represents all partners' views in medication management.

Where necessary, the MAC may need to obtain additional expert advice from other health professionals – for example, geriatricians, clinical pharmacologists, physiotherapists, dieticians, psychiatrists and other allied health professionals. This is relevant for specific issues, such as:

- The use of psychotropics, opioid analgesics and other high-risk medicines, as well as complementary medicines
- The non-pharmacological management of health conditions.

Implementation – key tasks and strategies

For the RACF

The RACF needs to:

- Refer to the *User Guide: Role of a Medication Advisory Committee*
- Give priority to the establishment of a clinical governance structure for medication management (refer Box 1)
- Develop and implement policies, procedures and guidelines for medication management that meet relevant national, state and territory legislative requirements
- Implement a risk-management system to identify, prioritise, monitor, manage and review risks associated with medication management
- Ensure systems are in place to record and measure change in medication safety risks – for example, mandatory and other quality indicators such as adverse events, incidents or reported care experiences – to update risk assessment reports and

* Community, accredited and/or quality use of medicines (QUM) pharmacist.

inform quality improvement (refer to Guiding Principle 4: Evaluation and quality improvement in medication management)
- Identify education and training requirements; assess the competency and training needs of the workforce in line with regulatory, legislative and organisational requirements and scope of practice, and the range of medicines used
- Ensure that any digital systems used for medication management are safe, secure and fit for purpose.

Box 1: Governance of medication management – a priority area for action

According to the User Guide: Role of a Medication Advisory Committee, assigning the governance of medication management to a relevant committee within the RACF's governance framework is a priority for action – for instance, a medication advisory committee or a clinical advisory committee.

It is also important for a multidisciplinary range of healthcare professionals to contribute their expertise to optimise care, medication management and outcomes for people receiving care.

User guide for establishing a medicines governance group

The *User Guide: Role of a Medication Advisory Committee* is a 'supplement' to the *Guiding Principles for Medication Management in Residential Aged Care Facilities*.

It aims to assist RACFs with review and/or implementation of a MAC under approved ToRs. The guide includes best-practice guidelines for establishing a MAC, a proforma ToR and agenda, an audit tool and a checklist to evaluate performance. The RACF can choose improvement strategies that are specific to its own local context, while ensuring they are meaningful and relevant to the organisation's governance framework, structure, location, workforce, and individual care recipients.

It is important for the RACF's Board of Management and Executive to provide sufficient resourcing to enable the MAC to:

- Be effective and perform its functions
- Meet regularly in person or virtually – for instance, on a quarterly basis
- Have a mechanism in place to consider urgent issues that may arise outside of the scheduled meetings.

It may be impractical for a small aged care facility to have its own MAC, because of its size. In such cases, the RACF may be represented at and function under the MAC governance of a larger organisation or aged care provider (for instance, a 'parent' organisation or head office). The larger organisation's MAC needs to provide guidance to the smaller aged care facility to ensure standardisation of policy and guidance, and consistency with decision-making across all facilities in the organisation.

Implementing the MAC's role

The *User Guide: Role of a Medication Advisory Committee* provides best-practice guidance and additional information on key aspects of the MAC's role. It describes the following four requirements:

1. Develop and endorse policies, procedures and guidelines and advise on legislation and standards

Refer to Potential policies, procedures and guidelines relating to medication management for RACFs for a range of medication management policies, procedures and guidelines that the RACF needs to consider. These are built upon:

- The National Medicines Policy[2]
- Those described in these *Guiding Principles for Medication Management in Residential Care Facilities*
- The Aged Care Quality Standards.[15]

The MAC must ensure that all policies, procedures and guidelines are consistent with relevant national, state and territory legislative requirements.

2. Advise on risk-management systems associated with medication management

In accordance with Standard 8: Organisational Governance of the Aged Care and Quality Standards[32], the organisation's risk-management strategy needs to identify and evaluate incidents (including complaints) and 'near misses' (both clinical incidents and incidents in delivering care and services).

The Australian Commission on Safety and Quality in Health Care's *Incident Management Guide*[35] includes best-practice principles of incident management.

Figure 4 illustrates the usual phases of incident management, and includes some reflective questions for the RACF to consider when setting up or reviewing its risk management systems.

The RACF needs to ensure the medication safety risks are recorded and the data or information is used for:

- Reporting to the National Aged Care Mandatory Quality Indicator program[33]
- Reporting to the Serious Incident Response Scheme[36]
- Developing internal quality improvement strategies
- Reporting adverse events
- Assessing clinical outcomes and care experiences, and to inform and update the riskmanagement system.

Refer to Guiding Principle 4: Evaluation and quality improvement in medication management, for further information on these topics.

Figure 4: Phases of incident management

Adapted from the Australian Commission on Safety and Quality in Health Care *Incident management guide*[35] 'Phases of incident management'.

3. Identify education and training needs for medication management

The MAC needs to support the provision of and access to education and training based on the specific needs of the facility, those receiving care and the healthcare professional workforce, including medicines-related information and decision support tools.

The RACF may need to assess the competency and training needs of the workforce in line with regulatory, legislative and organisational requirements, scope of practice, and the range of medicines used.

Nurses and other care staff (however titled) also need to be trained on how to identify and escalate medication management issues.

Ongoing education and training needs to cover medication safety issues and risk mitigation strategies, such as those outlined within the *User Guide: Role of a Medication Advisory Committee*.

4. Monitor effectiveness and performance as well as implement quality improvement strategies for medication management

Policies, procedures and guidelines for the systematic evaluation of medication management need to be in place. These should support the actions outlined in accreditation standards.

For instance, evaluation processes need to include:

- Routine, scheduled evaluation activities
- Incident and error review
- Follow-up actions such as process redesign or education and training
- Review of the effectiveness of these followup actions.

Evaluation also needs to consider how medication management relates to other service functions – such as pharmacy services, purchasing and supply arrangements, facility records management and information technology systems.

MACs need to be both proactive and responsive to issues arising and develop an action plan accordingly. Suggested strategies include:

- Reviewing medicines utilisation trends and usage patterns in the RACF
- Measuring and improving a person's experience with medicines – for instance, use of survey data or feedback from individuals
- Planning and driving quality use of medicines (QUM) and medication safety initiatives or strategies
- Ensuring that any digital systems used for medication management are safe, secure and fit for purpose.

MACs also need to establish mechanisms to determine and assign priority to its evaluation and quality improvement activities – aligned to the RACF's risk-management system.

For the healthcare workforce

RACF's staff need to:

- Have access to the most current policies, procedures and guidelines
- Be given the opportunity to provide feedback on the development of new and/or revision of existing policies, procedures and guidelines
- Understand their roles and responsibilities relating to medication management within the RACF
- Participate in education and training as determined by the MAC and/or Executive or Board of Management.

For the individual, their carer and/or family

An individual receiving care within residential aged care and their carer, family and/or substitute decision-maker should be invited to become members on the RACF's MAC or equivalent medicines governance committee. Involvement provides the opportunity for:

- Their views to be considered on the committee's standing agenda items
- Them to participate in the development and review of medicines-related policies, procedures and guidelines.

In addition, an individual receiving care and their carer and/or family should:

- Be encouraged to provide feedback on the management of their medicines
- Be provided with advice on how to lodge a complaint or incident, including the process for escalating their complaint if not satisfied – for instance, to the Aged Care Quality and Safety Commission, or otherwise
- Expect to receive feedback on and satisfactory resolution of their medicines-related complaints.

Potential policies, procedures and guidelines relating to medication management for RACFs*

- Antimicrobial stewardship and infection control
- Authorised initiation of medicines
- Avoiding use of unsafe terms and abbreviations
- Complementary and self-selected nonprescription medicines
- Continuity of medicines supply
- Emergency stock of medicines
- Guidelines for supporting individuals who administer their own medicines (selfadministration)
- Incident management, including 'near misses'
- Keeping individuals safe (safeguarding)
- Managing acute exacerbations of a person's chronic illness – 'sick days'
- Management and reporting of medication incidents and suspected adverse drug reactions (ADRs)
- Managing and sharing information about an individual's medicines amongst the interdisciplinary team, including when they transfer between care settings
- Managing deprescribing and the use of 'deprescribing guides'
- Managing high-risk medicines (for example, psychotropics, opioid analgesics, anticoagulants and insulin)
- Medication reconciliation
- Medication review

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* *User Guide: Role of a Medication Advisory Committee*.

- National Mandatory Aged Care Quality Indicator[33] and Serious Incident Reporting Scheme[36] (SIRS) reporting
- Prescribing, receiving, dispensing and administration of medicines
- Procurement, supply, storage, security, handling and disposal of medicines
- Provision of information about medicines to individuals and their carers, including during day leave/family leave
- Safe implementation, use, and optimisation of electronic medication management (electronic NRMC)
- Use of standard forms such as the National Residential Medication Chart (NRMC).

Resources

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

Reflective questions

- How does the RACF ensure that the composition of its MAC is multidisciplinary, and that it meets regularly to consider all the medication management issues that arise within the RACF?
- What role does the MAC have in the development of RACF policies, procedures and guidelines for medication management?
- What processes and supports are in place to support the MAC to monitor, review and evaluate the safe and quality use of medicines within the RACF?
- What is the mechanism for the MAC to address and report medicines-related issues and its relationship with the RACF management and Board?
- What and how does the RACF use nationally reported data or local information to inform quality improvement activities? For example, how is regional data from the *Australian Atlas of Healthcare Variation*[37] used?
- How does the RACF:
  - Ensure that those receiving care, their carers and/or family have a voice in the management of medicines within the facility?
  - Involve those receiving care, their carers and/or family in the co-design of quality improvement activities?
  - Optimise appropriate clinical governance of medication management?
  - Support development and implementation of policies, procedures and guidelines for medication management?
  - Identify and manage risks with medicines use?
  - Identify education and training requirements for medication management?

Guiding Principle 4: Evaluation and quality improvement in medication management

The RACF routinely reports on the mandatory medication management indicators and regularly reviews, identifies and evaluates risk within each area of medication management, taking follow-up action where required.

Summary and intent

In accordance with Standard 8: Organisational Governance of the Aged Care Quality Standards[15], the residential aged care facility's (RACF) governance and risk-management strategy identifies and evaluates incidents and 'near misses' (both clinical incidents and incidents in delivering care and services).

Risks associated with medicines are managed within a risk management framework which includes applying a continuous quality improvement (CQI) or cyclical approach to improving processes and outcomes in medication management.

An effective quality improvement system operates across the RACF and is overseen by a medicines governance group – for instance, a medication advisory committee (MAC) – which is essential to ensure the safe and quality use of medicines (QUM) (refer to Guiding Principle 3: Clinical governance of medication management).

An effective quality improvement system involves:

- Monitoring care outcomes from medicine use
- Resolving medicines-related problems
- Reducing risk from medicines-related harm
- Improving the quality of care and experience for people in residential aged care.

Early intervention in the medication management pathway (refer to Figure 3) can prevent adverse events occurring later in the pathway. This includes:

- Evaluation of all aspects of medication management (including medication reconciliation and medication review)
- Identifying safety and quality measures, and monitoring and reporting on performance
- Identifying areas of risk and opportunities for improvement in medication management (for example, timely access to medicines at transitions of care)
- Implementing and monitoring improvement strategies
- Involving care recipients and the workforce.

RACFs participate in the National Aged Care Mandatory Quality Indicator Program[38] by reporting on the medicines-related indicators.

Additional evaluation can occur at individual, group and facility-wide level, for example, when:

- An accredited pharmacist is performing a medication review or a nurse is conducting an assessment for self-administration
- A trend is identified in the use of the same types or classes of medicines (for example, psychotropic medicines, analgesic medicines or medicines for bowel management); this may be through review against clinical and therapeutic guidelines and in drug utilisation and evaluation (DUE) activities
- Managing the supply, storage, handling, administration, security, and disposal of certain classes of medicines used within the facility – for example, cytotoxic

medicines and associated waste; opioids or Schedule 8 medicines (refer to Guiding Principle 13: Storage and disposal of medicines)
- Reporting and monitoring medicines-related outcomes or problems – for example, adverse drug reactions, medication incidents and complaints – through adverse drug reaction and incident surveillance systems
- Monitoring dose administration aids (DAAs) for packing errors
- Reviewing feedback on staff education and training activities in medication management or medication safety
- Auditing medicines-related processes such as administration practices and policy adherence, and alteration of oral dose forms
- Implementing new digital technology or systems for medication management – such as the electronic National Residential Medication Chart (eNRMC) system.

Implementation – key tasks and strategies

For the RACF

The RACF needs to establish an environment that:

- Fosters continuous quality improvement in medication management
- Meets the medicines-related needs of all care recipients
- Supports continuity of medication management across different care settings within the RACF, and at transitions of care to hospitals and the community.

To achieve this it needs to:

- Use information from the National Aged Care Mandatory Quality Indicator program[33] and internal quality improvement strategies, any Serious Incident Response Scheme (SIRS)[36] reportable incidents, the facility's incident management system, adverse events, complaints, clinical outcomes and reported care experiences – for instance, using patient-reported experience measures (PREMs), to inform and update risk assessments and the risk-management system
- Consider participation in large-scale aged care outcome monitoring of medicines-related indicators – such as high sedative load, antipsychotic use, chronic opioid use, antibiotic use and medicines-related adverse events[39]
- Involve and engage the individual receiving care and their carer, family and/or substitute decisionmaker by
  - including them in discussions on the review of medication incidents (for example, as a representative on the medicines governance group)
  - involving them in the co-design of quality improvement activities
  - requesting feedback on their experience with medication management – for example, via survey
  - responding to their complaints.

With regard to evaluation, the RACF needs to:

- Ensure that the evaluation of medication management is identified within the RACF's risk-management framework
- Develop policies, procedures and guidelines, endorsed by the RACF's medicines governance group, for the systematic evaluation of medication management
- Develop evaluation processes that can include
  - routine, scheduled evaluation activities
  - incident reporting and error review
  - follow-up actions or implementation of improvement strategies, such as process redesign or education and training
  - review of the effectiveness of follow-up actions or improvement strategies
- Involve the workforce in the review of evaluation activities and the development and implementation of improvement strategies

- Consider how the RACF's evaluation of medication management relates to and integrates with other service functions – such as pharmacy services, purchasing and supply arrangements, facility records management and information technology systems
- Consider accessing and utilising a pharmacist to assist the RACF and MAC by providing a QUM Service[40]; this is separate from the funded residential medication management review services but can be conducted by the same accredited pharmacist, a pharmacist from the medication supply pharmacy, or the RACF's on-site pharmacist
- Evaluate its application of each Guiding Principle by considering and answering the series of 'reflective questions'
- Formulate additional locally-relevant 'reflective questions' to help measure, report on, review, develop and improve the safety and quality of all aspects of medication management within the RACF.

The *User Guide: Role of a Medication Advisory Committee* is available to assist the RACF and includes best-practice guidelines on riskmanagement systems associated with medication management.

The RACF needs to be both proactive and responsive to medicines-related issues arising from:

- Review of medicine utilisation trends and usage patterns within the RACF
- Feedback from individuals receiving care, or their carers and/or family, on their experience with medicines.

The RACF's medicines governance group needs to assist the organisation to develop an action plan that can be used to:

- Drive change in medication management and implementation of medication safety initiatives
- Monitor the effectiveness of improvements or strategies that have been implemented, including regular review of the success or sustainability of implementation.

To assist with and guide quality improvement, the RACF can refer to and consider use of the tools within the *User Guide: Role of a Medication Advisory Committee*.

For the healthcare workforce

RACF staff need to be involved in the conduct and review of evaluation activities as well as the development and implementation of improvement strategies.

Healthcare professionals can also be involved through:

- Participation in serious incident review
- Incident or medicine utilisation trend analysis
- Providing feedback to individual healthcare staff or a group of healthcare staff – for instance, via an education or training session.

For the individual, their carer and/or family

An individual receiving care within residential aged care and their carer, family and/or substitute decision-maker should be involved in the evaluation of the RACF's medication management. This could occur as part of their involvement and input on the RACF's MAC or equivalent medicines governance committee.

An individual receiving care and their carer and/or family are well placed to provide insight on:

- How best to respond to individual feedback or complaints received from care recipients
- The assessment of care experiences and/or survey responses

- Design and implementation of improvement strategies.

Resources

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

Reflective questions

- What and how does the RACF use nationally reported data or local information to inform quality improvement activities? For example, how is regional data from the *Australian Atlas of Healthcare Variation*[37] used?
- How does the RACF involve care recipients in co-design of quality improvement activities?

Further questions

In addition to the questions listed above, also refer to:

- The series of 'Reflective questions' included within each Guiding Principle
- Relevant reflective questions included within each of the relevant Aged Care Quality Standards.[15]

Guiding Principle 5: Information resources

The RACF ensures access to current and evidence-based medicines-related information, tools and resources for each person receiving care, their carers, the RACF healthcare team and visiting healthcare providers.

Summary and intent

Quality and evidence-based medicine information supports the safe and quality use of medicines (QUM). Individuals receiving care in a residential aged care facility (RACF), their carers and/or family, the RACF healthcare team and visiting healthcare providers need to have access to current and relevant medicines-related information to support optimal medication management for each person receiving care. Resources need to include information focussing on safe and effective use of medicines in the treatment of older people.

The RACF's medicines governance group or MAC needs access to suitable evidence-based information resources to inform the development of medicinesrelated policies, procedures and guidelines.

RACF healthcare professionals and visiting healthcare providers need information to support and guide their professional medication management responsibilities.

The individual receiving care, their carer, family and/or substitute decision-maker needs to receive information that:

- Is current and evidence-based
- Is person-centred and tailored to meet their individual health literacy needs
- Supports decision-making about their medicines
- Supports informed consent
- Assists the person to manage and self-administer their own medicines.

The provision of appropriate medicines-related information, especially where medicines are commenced and/or ceased, is important for safety. This is particularly important at transitions of care – for example, when changes to an individual's medicines are made during a recent hospital admission.

Medicines-related information needs to be supplemented and reinforced as required and/or when requested when requested to support an individual's ongoing understanding about their medicines or medicines literacy (refer to Guiding Principle 1: Person-centred care and Guiding Principle 2: Communicating about medicines).

Medicines-related information

The medicines-related information should be:

- The policies, procedures and guidelines for health care – including, but not limited to, those of the RACF
- The RACF's medication management policies, procedures and guidelines – including documentation, reporting and evaluation of medicines use
- Professional practice standards and guidelines and decision support tools
- Legislative and regulatory standards – such as state and territory drugs and poisons legislation
- Current, evidence-based prescribing, dispensing and administration of medicines.

The medicines-related information also needs to be:

- Relevant to the RACF's care delivery and workflows of the organisation

- Relevant to the RACF's range of healthcare professionals and visiting healthcare providers
- Relevant to the treatment of older people, including individuals with complex health conditions
- Person-centred and tailored to meet health literacy needs of the individual and their carer and /or family
- Available in an appropriate format and language for the user.

The medicines-related information needs to include:

- Specific medicines-related resources – such as product information (PI) and consumer medicine information (CMI)
- Resources or tools to assist people in self-administering their own medicines – such as medicines lists
- Specialised guidance on the use of medicines for specific health conditions – such as therapeutic and clinical guidelines, as well as complementary medicines.

Implementation – key tasks and strategies

For the RACF

The RACF needs to ensure access (including online access) to medicines-related information, tools and resources that:

- Are current and evidence-based
- Support RACF healthcare professionals, visiting healthcare providers and other service providers to provide safe and quality use of medicines
- Enable the individual receiving care and their carer and/or family to be informed about their medicines and be involved in the decision making about their treatment options.

Accessing and using appropriate medicines-related information resources and tools is integral to the RACF's quality assurance, education and information technology policies, procedures and guidelines.

To ensure effective use of information resources, the RACF needs to consider how to make the medicines-related resources readily accessible to different users, including after-hours and remotely. Provision of information needs to consider the health literacy, level of understanding of medicines information, language skills, specific needs, and cultural sensitivities of the person seeking the information.

The RACF has a responsibility to:

- Ensure that relevant national, state or territory legislation is available for reference and use
- Ensure that medicines-related information is available to the healthcare workforce, visiting healthcare providers and the individual receiving care and their carer and/or family
- Support healthcare professionals to provide and discuss medicines-related information with the individual and their carer and/or family when treatment options are being considered (including the review of and/or deprescribing medicines) and when treatment decisions have been made
- Ensure that healthcare professionals (including visiting healthcare providers) have access to relevant, evidence based, up-to-date medicine information (including reference materials)
- Establish and regularly review processes to provide and maintain a range of medicinesrelated information
- Provide education and training on how to access and use medicines-related information and decision support tools for healthcare professionals and non-clinical

staff; a QUM pharmacist could assist in providing education and training services for the RACF.

The RACF must ensure that organisational policies, procedures, and guidelines include the requirement to:

- Provide medicines-related information to the individual receiving care and their carer and/or family as part of any clinical consultation, using written information, if relevant – for instance, to help inform the person about any newly prescribed medicine, and/or the need to cease (or deprescribe) a medicine, or modify the dose or formulation of a medicine
- Obtain informed consent for treatment with specialised or unregistered medicines – for example, Special Access Scheme medicines or offlabel use of medicines
- Document in the healthcare record that the individual and their carer and/or family have been informed and/or provided information about their medicines; documentation may be included as a part of the informed consent process, within the person's healthcare record (paper-based or electronic), and/or on the medication chart (paper-based or electronic) – for example, the NRMC or eNRMC.

For the healthcare workforce

Prescribers, pharmacists and registered nurses need to:

- Access and use up-to-date and evidence-based medicines-related information, decision support tools and resources when
  - providing advice
  - prescribing, dispensing and administering medicines
  - making decisions to deprescribe medicines, or modify the dose or formulation of a medicine
- Discuss and reinforce 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 the person receiving care 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 and 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
- Participate in the development and review of medicines-related policies, procedures and guidelines.

Medicines-related information needs to be available to support all stages of the medication management pathway. This includes access to information on:

- Pharmacological and non-pharmacological treatment options
- Potential benefits and possible side effects of medicines – for example, before deciding to prescribe or deprescribe
- Prescribed medicines – for example, the PI and CMI
- Appropriate administration or self-administration of medicines – for example, to educate the person receiving care on self-administration techniques, such as for inhalers.

Access to good quality medicines-related information:

- Supports conversations about medicines between healthcare providers and the individual and their carer and/or family

- 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 and health information by healthcare providers.

For the individual, their carer and/or family

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

The individual receiving care and their carer, 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 shared decision-making and better adherence to medicines-related treatment plans.

The information should be person-centred and tailored in a form that can be used and understood, and is sensitive to the person's special or specific needs – for example, culturally sensitive; considers the level of health or medicines literacy; available in the person's native language (refer to Guiding Principle 1: Person-centred care and Guiding Principle 2: Communicating about medicines).

The format of medicines-related information needs to be appropriate for the individual and their carer and/or family. Technology should be used wherever possible, acknowledging that some people will prefer paper-based materials and may require large print versions.

Information on how to access medicines-related information should be included in local resources, such as brochures about the RACF's care and services.

This will equip people and their carers to discuss treatment options, including medicines use, as part of their care. The information will also help guide shared decision-making conversations about a person's medicines, including the safe effective use of complementary and non-prescription medicines and any newly prescribed medicines.

Resources

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

Guiding Principle 6: Selection of medicines

The RACF supports informed evidence-based decision-making for the selection of medicines used within the facility.

Summary and intent

Older people have increasingly complex medicines regimens. These are prevalent in residential aged care facilities (RACF) and can be challenging to administer. The 2020 Pharmaceutical Society of Australia (PSA) report *Medicine safety: aged care*[41] states that:

- 98% of people living in aged care facilities have at least one medicines-related problem identified at review
- Up to 80% are prescribed potentially inappropriate medicine
- 17% of unplanned hospital admissions by people living in aged care facilities are caused by an inappropriate medicine.

A quality use of medicines (QUM) approach to the safe and appropriate selection, use and management of medicines is supported by the RACF. This includes:

- Selecting management options wisely, including non-medicine or non-pharmacological alternatives
- Choosing suitable medicines if a medicine is considered necessary
- Using medicines safely and effectively to achieve the best possible outcomes.

The decision to select and use a medicine within a RACF may be according to the choice or recommendation of the person being cared or their prescriber. It may also occur because of:

- The person, their carer and/or family requesting a non-prescription, 'over-the-counter' (OTC), complementary or alternative medicine (refer to Guiding Principle 7: Complementary and self-selected non-prescription medicines)
- A prescriber ordering a medicine for an individual
- A nurse initiating a medicine from an approved list of medicines or medication treatment protocols.

Appropriate prescribing and medicine selection

Best practices include:

- Avoiding inappropriate Poly-pharmacy
- Review of a person's Drug Burden Index (DBI)
- Deprescribing
- Anticipatory prescribing for palliative medicines – for instance, to enable timely access to medicines required for effective symptom management in palliative and end-of-life care
- Management plans for acute exacerbation of a chronic disease – for example, heart failure, chronic obstructive pulmonary disease (COPD), asthma, diabetes
- Appropriate use of high-risk medicines – for example, antimicrobial stewardship in aged care and reducing the inappropriate use of psychotropic medicines.

In addition, given the medication management needs of people living in residential aged care are now more complex, other issues to consider include:

- Assessment and management of pain leading to selection and use of appropriate analgesia
- Assessment and management of delirium

- Acute exacerbation of a chronic illness
- Day-to-day management of an acute illness ('sick days')
- People with special or specific needs – for example, a person with a disability; with cognitive impairment; from a culturally and linguistically diverse (CALD) background; from an Aboriginal and Torres Strait Islander community
- End-of-life and palliative care prescribing of medicines.

When necessary, the workforce is provided with education and training – for example, according to recommendation of the RACF's medicines governance group (refer to Guiding Principle 3: Clinical governance of medication management).

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 of more medicines by the same person.[42] Medicines include prescription, complementary and non-prescription (or OTC) medicines.

Due to the higher prevalence of multiple chronic co-morbidities and increased frailty with age, older people are likely to take many medicines. Whilst not every case of Poly-pharmacy has negative consequences, the more medicines a person takes, the higher the risk of adverse drug events. The potential for medicines to interact increases with the number of medicines being taken.

Older people taking five or more medicines are at higher risk of delirium and falls, independent of the medicines' indications. 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 Poly-pharmacy (refer to Guiding Principle 7: Complementary and self-selected non-prescription medicines).

Deprescribing

Deprescribing is defined as the thoughtful and planned process of stopping or reducing the dose of inappropriate medicines that[43,44]:

- 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.[49,50]

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

Prescribing of potentially inappropriate medicines can add to a person's drug burden and is independently associated with adverse drug events, hospitalisation, poor health-related quality of life, and death.[5,45,46] For all classes of medicines, nonpharmacological management options should be optimised to help achieve the best possible outcomes.

The overall goal of deprescribing should be to improve a persons' 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.

Medicines stewardship

Medicines stewardship aims to ensure the safe and quality use of medicines by:

- Monitoring their use (for instance, trends in medicines' utilisation)
- Coordinating interventions to optimise medicines use
- Working collaboratively with healthcare providers and care recipients.

Stewardship programs are known to make a difference in the hospital setting, and could be adapted for residential aged care for high-risk medicines, such as:

- Antimicrobials
- Psychotropics
- Other high-risk medicines, including opioids.

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)[47] 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 RACF

The RACF needs to:

- Ensure existing processes for the selection of medicines used within the facility, reflect and support a QUM approach
- Have policies, procedure and guidelines in place, which comply with relevant state and territory legislation and are endorsed by the RACF's medication advisory committee (MAC), and recognise
  - the range of healthcare professionals that are able to prescribe medicines – for example, general practitioners, nurse practitioners, dentists, podiatrists and optometrists
  - selection of medicines by registered and/or enrolled nurses from approved lists and medication treatment protocols – for instance, in accordance with Guiding Principle 8: Authorised initiation of medicines by nurses
  - self-selection of medicines including non-prescription, complementary and traditional medicines by individual and their carer and/or family (refer to Guiding Principle 7: Complementary and self-selected non-prescription medicines)
- Have a clear understanding of the role of each member of the facility's healthcare team and, where relevant, take responsibility for the education and training of their workforce

- Ensure that members of the healthcare workforce have the knowledge, skills, competence and delegated regulatory and legal authority to manage, use, handle and administer medicines.

The RACF's policies, procedures and guidelines on medicines selection and stewardship also need to cover the range of complexities of those receiving care including:

- Management of people with conditions such as diabetes, dementia, behavioural disturbances, falls, or incontinence
- Assessment and management of pain leading to selection and use of appropriate analgesia
- Assessment and management of delirium
- Day-to-day management of an acute illness or acute exacerbations of a person's chronic illness – 'sick days'
- People with special or specific needs – for instance, a person with a disability; with cognitive impairment; from a culturally and linguistically diverse (CALD) background; from an Aboriginal and Torres Strait Islander community
- End-of-life and palliative care prescribing of medicines including for bowel management.

It is important for healthcare professionals involved in medication management to have access to and promote the use of appropriate, current and evidence-based information resources by all those selecting medicines and to inform their decision-making (refer to Guiding Principle 5: Information resources).

Healthcare professionals should be encouraged and supported to:

- Identify and implement strategies that support both effective medicines use and nonmedicine alternatives
- Establish processes to support effective interdisciplinary communication and collaboration between care team members, individuals and their carers and/or families (refer to Guiding Principle 2: Communicating about medicines)
- Establish and maintain accurate and reliable records such as medication charts (paper-based or electronic), laboratory results and allergy/adverse drug reaction history, and a person's My Health Record (refer to Guiding Principle 9: Documentation of medication management)
- Establish and support referrals to and between relevant healthcare practitioners – for example, referrals for medication review for an individual, such as a residential medication management reviews (RMMR) (refer to Guiding Principle 11: Medication review)
- Assess medicines use and practice at the facility level using methods such as drug utilisation evaluation, to identify inappropriate use of medicines (refer to Guiding Principle 4: Evaluation and quality improvement in medication management).

Digital medication management systems, such as the eNRMC, that support safe and appropriate medicines selection need to be implemented (refer to Guiding Principle 9: Documentation of medication management).

For the healthcare workforce

Prescribers must be competent in prescribing medicines safely and effectively and within a person-centred approach that takes into account an individual's decision about their treatment options. They must also:

- Be aware of and comply with all legal requirements for prescribing that are relevant to their profession
- Prescribe within their scope of practice
- Communicate and coordinate treatment with other treating healthcare providers
- Adhere to the principles of QUM.

To facilitate the best outcomes from the selection and use of medicines prescribers need to:

- Understand the person and their cultural, clinical and specific needs
- Understand the available treatment options and their implications
- Discuss and agree on a plan in partnership with the person
- Review treatment response, including adherence and/or the need to cease or modify treatment.

Guidance on appropriate prescribing and medicine selection practices can be found in the *RACGP aged care clinical guide (Silver Book)*.[48] This includes avoiding inappropriate polypharmacy[49] and deprescribing[43] as well as palliative and end-of-life care.[50]

Prescribers also need to focus on the appropriate use of high-risk medicines such as antimicrobial stewardship in aged care[51] and reducing the inappropriate use of psychotropic medicines.[52]

To avoid unnecessary admission to hospital, prescribers need to consider and communicate the best options for the day-to-day management of an acute illness or acute exacerbation of a person's chronic illness – 'sick days'.

This could be achieved by developing an individual management plan on how best to manage certain medicines and conditions during acute illness. This includes consideration of:

- Which medicines should be temporarily ceased or withheld to reduce the risk of adverse events
- Which medicines may require dose escalation – for example, insulin, long-term steroids
- When medicine use can 'return to normal' after the acute illness has resolved
- How to manage medicines packed in DAAs during acute illness – for example, refer to the pharmacist to ensure appropriate identification and/or removal of the medicines to be ceased/withheld.

For the individual, their carer and/or family

A person receiving care within a RACF should expect to be:

- Supported with medicines-related information – for example, consumer medicines information – that is tailored to their special or specific needs and health literacy
- Supported to make choices about their care
- Involved and partner in decisions about their treatment options (either with a medicine or a non-pharmacological alternative).

Resources

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

Reflective questions

- How does the RACF support a QUM approach to the selection of medicines used within the facility?
- How does the RACF ensure that the policies, procedures and guidelines, as well as current evidence-based information resources, are readily available to assist the RACF healthcare professionals, visiting healthcare providers, individuals and their carers and/or families with informed decision-making and selection of medicines?
- How is medicines use in the facility reviewed and evaluated and how are the results used to improve the safety and quality of the selection of medicines? (Refer to Guiding Principle 4: Evaluation and quality improvement in medication management.)

Guiding Principle 7: Complementary and self-selected non-prescription medicines

The RACF supports informed selection and safe use of complementary and selfselected non-prescription medicines for each person receiving care.

Summary and intent

Complementary medicines and non-prescription medicines are widely used in the Australian community. They are available for self-medication by individuals through retail outlets and practitioners of complementary medicines and therapies.

Complementary medicines include herbal medicines, some vitamin and mineral supplements, other nutritional supplements, homeopathic formulations, and traditional medicines such as Chinese, Ayurvedic and Australian Indigenous medicines.

Complementary medicines may also be used as alternative medicines.

Complementary medicines are commonly used by older people and contribute to Poly-pharmacy. About two-thirds of Australians aged 75 years and over are taking five or more medicines including complementary and non-prescription medicines.[37]

There is limited evidence of efficacy for most complementary medicines. However, some complementary medicines are commonly used – for example, herbal products such as echinacea and ginkgo biloba.

Complementary medicines have the potential to cause adverse reactions or interact with conventional medicine. For instance, echinacea may interact with psychotropic medicines and ginkgo biloba may increase the risk of bleeding in people taking the anticoagulant warfarin.

Examples of non-prescription medicines include cough mixtures, simple analgesics and antacids.

Safe and quality use of complementary and non-prescription medicines are part of medication management in RACFs. This includes the documenting of complementary and nonprescription medicines as part of a medication history taking, within the medication chart (paperbased or electronic) and ensuring safe storage and disposal.

People receiving care in a residential aged care facility (RACF) may select, or ask their carers to select, and provide complementary and nonprescription medicines. These medicines must still be prescribed and documented on the medication chart (refer to Guiding Principle 9: Documentation of medication management).

The individual receiving care, their carer and/or family need to have access to current evidencebased information on complementary and nonprescription medicines and are encouraged to inform prescribers, pharmacists and nurses of any complementary and non-prescription medicines they are taking.

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.

Complementary medicines

Complementary medicines are used alongside conventional medical treatment.

Complementary medicines include a wide range of products and treatments with therapeutic claims that are not presently considered part of conventional medicine. Complementary medicines may also be termed ‘natural medicines’ and ‘holistic medicines’.

Alternative medicines

Alternative medicines use is when the complementary medicines, products and treatments referred to and described above are used instead of conventional medical treatment.

Non-prescription medicines

Non-prescription medicines are generally available to the individual and their carer and/or family. Some non-prescription medicines can only be sold by pharmacists (Pharmacist Only Medicines) or in a pharmacy (Pharmacy Only Medicines); others can be purchased through non-pharmacy outlets such as supermarkets. Non-prescription medicines are also known as overthecounter (OTC) medicines. Examples include:

- ‘Pharmacist Only Medicines’, such as inhalers or puffers to relieve asthma
- ‘Pharmacy Only Medicines’, such as medicines to treat symptoms of allergy
- Medicines for general sale, such as some pain relievers (analgesics) in small pack sizes, and vitamins.

Polypharmacy

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

Implementation – key tasks and strategies

For the RACF

The RACF takes a safe and quality-use-ofmedicines approach to the self-selection and use of complementary and non-prescription medicines.

The RACF needs to:

- Develop medication management policies, procedures and guidelines for the recording and review of complementary and self-selected nonprescription medicines used by individuals and within the facility
- Ensure medication management policies, procedures and guidelines on complementary and self-selected non-prescription medicines
  - are current, evidence-based and consistent with current national, state and territory legislation
  - recognise that complementary and non-prescription medicines may be selected and used by an individual and that these may be commenced at any time as part of the individual’s, their carer’s and/or family’s choice
  - include advice on the recording or documentation of complementary and non-prescription medicines on the person’s medication chart and updating the person’s own medicines-related records – such as My Health Record or medicines list[53]
  - advise on how to report any suspected adverse events to the Therapeutics Goods Administration (TGA) via the medicine’s governance group (refer to Guiding Principle 3: Clinical governance of medication management)
  - provide guidance on the safe storage and disposal of complementary and nonprescription medicines, including a review of expired products (refer to Guiding Principle 13: Storage and disposal of medicines).

Ideally, the RACF's medicines governance group has access to a healthcare professional with specialist expertise in complementary medicines (refer to Guiding Principle 3: Clinical governance of medication management).

For the healthcare workforce

Prescribers and other healthcare professionals (including visiting healthcare providers):

- Have access to current and evidencebased information on complementary and nonprescription medicines
- Encourage the individual receiving care (supported by their carer and/or family) to inform them about their use of complementary and nonprescription medicines
- Ensure the individual receiving care, their carer and/or family have access to evidence-based information on complementary and non-prescription medicines
- Document and administer complementary and self-selected non-prescription medicines in the same manner as prescription medicines
- Report suspected adverse events related to complementary and non-prescription medicines to the TGA via the medicine's governance group.

Prescribers and pharmacists:

- Explain that complementary and non-prescription medicines are still medicines, and they can have side effects as well as benefits and can interact with other medicines
- Record and reconcile the use of complementary and self-selected non-prescription medicines as part of the person's medication history, particularly at transitions of care
- Routinely ask the individual and their carer and/or family about complementary and nonprescription medicines they might be taking – for instance, during a medication review
- Record the use of complementary and nonprescription medicines in My Health Record and/or update a person's medicines list.[53]

Prescribers need to support a person's choice as part of informed decision making to safely prescribe and document all medicines (including complementary and self-selected non-prescription medicines) on the person's medication chart.

Nurses also routinely need to ask the person and their carer and/or family about complementary and self-selected non-prescription medicines they might be taking.

Other RACF staff (personal care workers, or however named) need to advise when they become aware that a person is taking or requests a complementary and/or non-prescription medicine that is not documented by the prescriber on the person's medication chart (refer to Guiding Principle 9: Documentation of medication management).

For the individual, their carer and/or family

An individual receiving care within residential aged care and their carer and/or family need to have access to current and evidence-based information about complementary and non-prescription medicines. They are encouraged to:

- Inform visiting or primary healthcare providers (for instance, their general practitioner) and other RACF healthcare professionals (prescribers, pharmacists, and nurses) when they are using, or providing, complementary and nonprescription medicines
- Discuss the use of complementary and nonprescription medicines with their prescribers, their pharmacist and nurses
- Ask about their side-effects given these are still medicines and whilst they may have benefits, they can be contraindicated; noting that some can interact with other prescribed medicines, which may impact their effectiveness, or, in combination, can cause side effects
- Record complementary and non-prescription medicines as part of their medicines list.[53]

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 does the RACF have in place for the management of complementary and self-selected non-prescription medicines?
- How has the RACF ensured that these policies, procedures and guidelines are consistent with the requirements of state or territory legislation?
- How does the RACF ensure that the individual receiving care and their carer and/or family are encouraged to inform RACF healthcare team and other healthcare providers about the use of complementary and nonprescription medicines?
- How does the RACF ensure that the use of complementary and non-prescription medicines is recorded on the person's medication chart (paper-based or electronic) and the person's My Health Record and personal medicines list?
- How does the RACF ensure a person's selfselected medicines are stored and disposed of safely?
- How are adverse events from complementary and non-prescription medicines recorded by the RACF and reported to the TGA, via the medicines governance group?

GUIDING PRINCIPLE 8

Guiding Principle 8: Authorised initiation of medicines by nurses

Where deemed appropriate, the RACF has policies, procedures and guidelines, endorsed by the RACF's MAC, in place to allow the authorised:

- Initiation of non-prescription medicines from an approved list
- Use and review of prescription medicine treatment protocols.

Summary and intent

Policies, procedures and guidelines are in place that are endorsed by the residential aged care facility's (RACF) medication advisory committee (MAC). These support healthcare professionals and ensure the authorised initiation of medicines by nurses relating to:

- Initiation of non-prescription medicines from an approved list
- Use and review of prescription medicine treatment protocols.

Generally, medicines in aged care facilities must be dispensed for the specific person and administered to the person receiving care on the written instructions of the prescriber.

The use of non-prescription nurse-initiated medicines are only appropriate for one-off or occasional use.

If a non-prescription nurse-initiated medicine needs to be used more than once, the person should be reviewed by their medical practitioner. Then, if considered appropriate, the medicine should be prescribed on the medication chart (whether paperbased or electronic) and a person-specific supply arranged.

The range of stock of Schedule 4 and Schedule 8 medicines held within an aged care facility should be limited.

Some states and territories may permit the use of treatment protocols (sometimes known as 'standing orders') where a nurse may initiate treatment with a prescription-only medicine under the protocol, usually only for urgent or emergency care.

A prescription medicine treatment protocol can only be issued by a medical practitioner, must be under the governance of the MAC, and must meet the national, state or territory legislative requirements. If permitted, the protocol must be:

- For the administration of a specific medicine(s)
- Used by a registered nurse
- Time limited.

Use of a prescription medicine protocol requires clinical judgement, and the registered nurse must first assess the specific circumstances for the person 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 nurse-initiated medicines

Occasionally RACF healthcare professionals are asked by an individual, or their carer or a family member, 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).

Registered nurses require authorisation to allow them to select and administer non-prescription medicines in these circumstances.

Depending upon state or territory legislation, authorised 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 endorsed by the MAC.
Prior agreement of the person's medical practitioner may also 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
- Medicines for emergency treatment, such as adrenaline (epinephrine) or glucagon.

While any non-prescription medicines authorised for nurse-initiation should be of low risk, the registered nurse 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 (however titled)

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.

5. 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. The prescriber must include PRN orders in the PRN section of the paper-based medication chart – for instance, on the NRMC – or within the electronic medication management system (such as, the eNRMC).

6. Palliative care and anticipatory prescribing

Good management of a person's symptoms in their last days of life is one of the concerns of the individual, their carer and/or family. The use of anticipatory prescribing allows prescribers to provide effective guidance to registered (including 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 – for example, for the relief of breakthrough pain.

7. Self-administration

Authorised initiation of medicines is distinct from self-administration of medicines where a person's medicines are already prescribed and documented on their medication chart (paper-based or electronic) (refer to Guiding Principle 14: Self-administration of medicines).

Implementation – key tasks and strategies

For the RACF

The RACF needs to:

- Assess the need for non-prescription nurseinitiated medicines and prescription medicine treatment protocols to be available for use across the facility's range of care settings
- Have policies, procedures and guidelines in place that comply with relevant state and territory legislation and are endorsed by the RACF's MAC
- Develop a list of medicines approved by the MAC to assist registered nurses to safely initiate, select and administer
- Ensure regular review of the policies, procedures and guidelines relating to
  - the MAC approved list of non-prescription nurse-initiated medicines
  - the use of prescription medicine treatment protocols
- Have information available on the consent process, including how a person receiving care can seek advice or treatment for the relief of minor symptoms and conditions/ailments
- Disseminate information to medical practitioners about the RACF's approved list of nonprescription nurse-initiated medicines, including
  - protocols outlining the assessment for use, dosage, indications
  - special precautions for each medicine.

The decision-making process for the approval of non-prescription nurse-initiated medicines and prescription medicine treatment protocols needs to be transparent and accountable, based on evidence of safety and justification of the need, and according to local circumstances.

Development and endorsement of policies, procedures and guidelines must be overseen by the RACF's MAC.

8. For non-prescription nurse-initiated medicines

The medicines governance group (or MAC) needs to ensure that policies, procedures and guidelines include the following information:

- How to ensure that the individual receiving care, their carer and/or family and their medical practitioner have consented to a registered nurse initiating non-prescription medicine
- That the medicines are only appropriate for onceonly or occasional use
- Sufficient detail to ensure that registered nurses can make informed decisions as to when and when not to select and administer a medicine from the 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 medication chart
- What to do if the use needs to become routine or ongoing, for instance, with review by the person's medical practitioner, and if required, ordered on the medication chart and a person-specific supply arranged.

9. For Schedule 2 or Schedule 3 medicines or medicine formulations that are not to be initiated

The medicines governance group (or MAC) needs to ensure that policies, procedures and guidelines also include advice about these medicines. This includes, for instance:

- Medicines delivered via inhaler devices
- Rectal or vaginal formulations
- Topical creams and ointments
- Ear or eye drops/creams/ointments.

Information about a person's right to request advice or treatment for the relief of minor symptoms and conditions/ailments needs to be made available to them. This needs to be included in the RACF's information booklet and/or a charter or similar.

10. For prescription medicine treatment protocols in states and territories where these are allowed

The medicines governance group (or MAC) must ensure that policies, procedures and guidelines describe the authorisation, use and routine monitoring within the RACF. Prescription medicine treatment protocols must be consistent with relevant state or territory legislation, may not be permitted or may be regulated and require a specific approval, authorisation or license. For example, in Queensland, a RACF may be required to have a Substance management plan for medicines (SMP)[54] that describes how 'standing orders'* might be set up and reviewed 'to ensure they remain appropriate for the circumstances and context and deliver improved health outcomes'.

Policies, procedures and protocols for the use of prescription medicine 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 general practitioner
- Be regularly reviewed by a medical practitioner and the MAC
- Specify the medicine, dose, route and frequency for use
- Clearly identify under what circumstances the 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, a registered nurse) who may administer the medicine.

Administration must be recorded on the person's medication chart.

The RACF need to ensure that:

- The use of prescription medicine treatment protocols is regularly monitored and reviewed as a standing item on the MAC agenda
- Registered nurses 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.

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* 'A standing order is a document that authorises a medicine to be administered or given as a treatment dose to or for a person or animal at the place, provided certain conditions are met. Since standing orders allow approved persons who are not authorised prescribers to make decisions to administer or supply a medicine to a patient or animal in the circumstances of the standing order, sufficient governance capability is required for a place in which standing orders are used' – Definition from Queensland Health's Medicines and Poisons (Medicines) Regulation 2021 (MPMR).

For the healthcare workforce

This Guiding Principle applies specifically to registered nurses who are authorised to:

- Initiate non-prescription medicines from an approved list
- Use and review prescription medicine treatment protocols.

All doses of medicines initiated by a registered nurse must be documented on the person's medication chart (paper-based or electronic) (refer to Guiding Principle 9: Documentation of medication management).

11. For non-prescription nurse-initiated medicines

Registered nurses need to refer to the MAC approved list of non-prescription nurse-initiated medicines when requested by individuals receiving care, or their carer and/or family, for advice or treatment for the relief of minor symptoms and conditions/ailments. The registered nurse may need to confirm that the person's medical practitioner has given their consent and that there are no contraindications for a non-prescription medicine to be initiated.

Whilst initiation of non-prescription medicines in the manner described should only be for onceonly or occasional use, if an individual, their carer and/or family are making regular requests, the nurse should request a review by the person's medical practitioner, and if required, ordered on the medication chart and a person-specific supply arranged.

12. Prescription medicine treatment protocols (however titled)

In states and territories where allowed, a person's medical practitioner is responsible for documenting prescription medicine treatment protocols according to the relevant legislative requirements. A prescription medicine treatment protocol must be condition-specific, time-limited, supported by a clinical assessment and clearly identify the circumstances for the medicine to be initiated. The medical practitioner is responsible for review of the prescription medicine treatment protocol, including its ongoing need.

For the individual, their carer and/or family

An individual receiving care within a RACF, and their carer, family and/or substitute decision-maker need to be provided with information on what to do if they need to seek assistance, including requesting advice or treatment for relief of minor symptoms or conditions/ailments. This information needs to include an explanation about:

- The consent process and involvement of the individual, their carer and/or family, registered nurse and medical practitioner
- How the RACF ensures a medicine ordered for once only or occasional use is on a MAC approved list
- How review by the person's medical practitioner is required for ongoing or routine use
- How all medicines administered are documented on the person's medication chart (refer to Guiding Principle 9: Documentation of medication management).

Resources

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

Reflective questions

- How does the RACF ensure its medication management policies, procedures and guidelines for authorised initiation of medicines by nurses are consistent with the requirements of relevant state or territory legislation?

- If the RACF has an approved list of nurse-initiated non-prescription medicines, what mechanism is in place for the periodic MAC review of this list as part of a qualityuse-of-medicines (QUM) activity?
- How does the RACF ensure that the administration and outcomes of nurseinitiated 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?

GUIDING PRINCIPLE 9

Guiding Principle 9: Documentation of medication management

To support safe prescribing, dispensing and administration of each person's medicines and effective communication of their medicines-related information, the RACF ensures that a current, accurate and reliable record of all medicines selected, prescribed and used is documented on their medication chart (paperbased or electronic).

Summary and intent

A major initiative to improve the safe use of medicines in Australia is the standardisation of medicines management documentation in health facilities through national standard medication charts. This initiative has included development of the National Residential Medication Chart (NRMC) which, although not mandated, is the recommended paper-based medication chart for use in residential aged care facilities (RACF).

Since the introduction of standardised paper-based medication charts, various digital or electronic health systems have been implemented, aimed at improving information documentation and system-wide integration in healthcare. Digital systems relating to medicines documentation are commonly referred to as electronic medication management[56] (eMM) systems which can include decision-support functionality and medicines administration records.

While many RACFs may have implemented electronic ways of documenting medication management, facilities may still have paper-based workflows or a hybrid combination that use both paper and electronic systems. The electronic National Residential Medication Chart (eNRMC)[57] medication management systems have been developed specifically for RACFs to streamline workflows for prescribing, administration, dispensing and Pharmaceutical Benefits Scheme (PBS) claiming of medicines.

Other digital or electronic health initiatives include active ingredient prescribing[58] as well as those within the National Digital Health Strategy, such as:

- Electronic health records – such as My Health Record[59]
- Electronic prescriptions[60]
- Real-time prescription monitoring[61]
- Telehealth.[62]

This Guiding Principle applies to both paper-based and electronic medication charts which are critical tools used to document medication management. They provide:

- A record of the prescriber's clinical intention for treatment
- An instruction for a medicine to be administered by a RACF nurse
- A prescription order for the pharmacist to dispense or supply a medicine (if an NRMC or eNRMC system is used)
- A record of administration of a medicine to the person receiving care.

Medication charts offer a repository for documentation of an accurate, reliable and complete record of a person's current medicines, including prescription, complementary and non-prescription medicines. Medication charts also enable and facilitate the monitoring, review and reconciliation of a person's medication management.

Whichever medication management system (paper-based, electronic or hybrid) is used by the RACF, this is optimised to ensure that accurate medicines-related information is available

to support safe transitions of care at all transition points. Examples of these transition points include medicines information transfer between the RACF and:

- Visiting healthcare providers
- Other care settings – such as community care, hospital, and peoples' various health providers including pharmacists.

The RACF may need to use additional documentation systems or formats, other than medication charts, to support safe continuity of medicines management across these transitions. Examples include the Interim Residential Medication Administration Chart or the Discharge Summary or the Aged Care Transfer Summary (ACTS) (refer to *Guiding Principles to Achieve Continuity of Medication Management*).

Other paper-based or electronic tools that are used to document medicines-related information (either within the RACF or remotely) and referred to when managing a person's medicines include:

- Paper-based or electronic health records
- Medication management plans (MMPs) – refer to Guiding Principle 11: Medication review
- Patient Medication Profiles – refer to
  - Guiding Principle 10: Medication reconciliation
  - Guiding Principle 11: Medication review
  - Guiding Principle 14: Self-administration of medicines
- A person's My Health Record
- A person's medicines list[53] (paper-based or electronic) – refer to
  - Guiding Principle 7: Complementary and self-selected non-prescription medicines
  - Guiding Principle 10: Medication reconciliation
  - Guiding Principle 11: Medication review
  - Guiding Principle 12: Continuity of medicine supply including in an emergency
  - Guiding Principle 14: Self-administration of medicines
  - Guiding Principle 15: Administration of medicines by nurses.

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.

Medication chart (paper-based)

Medication charts support the delivery of appropriate care for people within RACFs. They:

- Are a documentation tool for ordering medicines and recording their administration
- Support all medicines prescribing, administration and dispensing requirements in one place.

Used optimally, medication charts will communicate information consistently between healthcare providers on all the medicines an individual is taking (or being administered) and their intended use. An accurate and reliable medication chart is an important information tool across the health and aged care sectors. It:

- Provides current information about the medicines a person is prescribed and taking
- Supports continuity of care and helps to reduce medication errors.

The National Residential Medication Chart (NRMC)[63] was developed by the Australian Commission on Safety and Quality in Health Care. It is designed to provide a consistent format for medicines orders and administration records and improve the processes for pharmacist dispensing and claiming for the supply of medicines under the Pharmaceutical Benefits Scheme (PBS) or Repatriation Pharmaceutical Benefits Scheme (RPBS). A key

feature of the NRMC is that the prescriptions (or medicine orders) and records of medicine administration are co-located.

Interim Residential Care Medication Administration Charts

Hospitals in Victoria, South Australia and Queensland use Interim Residential Care Medication Administration Charts to assist continuity of medication management when a person transfers to a RACF from hospital. These charts, prepared by the hospital prior to discharge, provide continuing medicines orders for up to seven days – until the person's own prescriber (for example, a medical practitioner or nurse practitioner) reviews and prescribes ongoing treatment.

Electronic National Residential Medication Chart (eNRMC) medication management systems

An eNRMC system is a type of eMM system developed specifically to meet the needs of RACFs. An eNRMC system will support medication management and can be legally used to prescribe, supply, and claim Pharmaceutical Benefits Scheme (PBS) medicines.

Implementation – key tasks and strategies

For the RACF

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

- Taking a facility-wide integrated approach to chart selection, use and review
- Consistently using recommended terminology and abbreviations in chart entries and instructions
- Accurately recording medication management activities such as medicines administration and medication review
- Regularly reconciling components of each medication chart, such as
  - prescribing, dispensing/supply and administration records
  - versions of the medication chart
- Regularly reconciling the medicines documented on the medication chart with a person's own medicines-related records (such as My Health Record or medicines list[53]) – for example, when a new medicine is commenced, the dose of an existing medicine is changed, or at transitions of care
- Monitoring the range of additional paper-based or electronic tools that are used (either within the RACF or remotely) to document medicinesrelated information
- Ensuring contingency arrangements are in place for electronic system downtime (planned or unplanned) – for example, when temporary use of a paper-based 'downtime medication chart' may be required
- Using digital systems, such as
  - eNRMC systems
  - communication platforms for information exchange between the RACF, primary healthcare providers and Local Health Networks
  - telehealth
  - My Health Record.

The RACF needs to:

- Ensure policies, procedures and guidelines are in place for a comprehensive medication management system, and include
  - documentation requirements (including what and where information should be documented), and how to escalate or resolve instances where information has been omitted

    - maintenance of a register of the healthcare professionals who are authorised to document on the medication chart
    - roles and responsibilities of healthcare professionals
    - education and training requirements for healthcare professionals
- Review and develop an implementation plan to transition to an eNRMC system in close collaboration with the RACF's executive, medicines governance group (or MAC) and other key stakeholders.

For a RACF looking to implement an eMM system – such as the eNRMC[57] medication management system – items to consider include medication management workflows, legislative requirements, and change management planning. Two guides are available to support the RACFs on its implementation journey: eNRMC.[57]

Some of the potential benefits associated with implementation of eNRMC systems include:

- Reduced medication safety risks from inconsistencies between prescriber records and paper-based medication charts, and less time spent by dispensing pharmacists reconciling these differences
- Reduced administrative burden for prescribers, nurses, pharmacists and others involved in a person's care
- Increased visibility of a person's complete medical record for prescribers, dispensing pharmacists and the RACF healthcare team
- Protection of an individual's privacy and confidentiality, as only authorised users can access information on a 'need to know' basis.

RACFs should review the interoperability between the range of digital tools and systems to enable seamless exchange of information. across systems. This may also require a reference to nationally recognised standard terminologies and software conformance. RACFs should:

- Work with software vendors to implement a suitable eMM system to streamline workflows for the prescribing, administration, dispensing and PBS claiming of medicines
- Ensure that the eMM system they adopt and implement meets PBS, state and territory legislative requirements for medication charts
- Ensure that the eMM system is listed on the Australian Digital Health Agency's Electronic Prescribing Conformance register.[64]

RACFs should also consider working with other local healthcare providers, Local Health Networks, Primary Health Networks (PHNs) to implement and/or integrate systems that will ensure consistency and compatibility in the transfer of medicines information and to support interoperability and continuity of care across providers and settings. This includes implementing the Interim Residential Care Medication Administration Charts (refer to *Guiding Principles to Achieve Continuity of Medication Management*).

For the healthcare workforce

The NRMC User Guides[63] and accompanying resources, along with the eNRMC guide for safe implementation[65], are available for RACFs to use. However, prescribers also need to ensure that:

- All medicine details are complete, including essential fields to satisfy legislative and PBS and RPBS requirements
- All written medicines orders are legible, clear and unambiguous
- The specific sections of the medication chart are used for
    - short-term medicines (used for antimicrobials)
    - PRN (as required) medicines – including the indication, for example, for pain in the neck
    - variable-dose medicines – for example, warfarin
    - insulin

  - nutritional supplements
  - non-prescription medicines (including complementary medicines) (refer to Guiding Principle 7: Complementary and self-selected non-prescription medicines)
- When any change (including to the strength, frequency, etc.) is made to a medicine order, the **current order must be ceased and a new entry made** on the medication chart.

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 does the RACF have in place to support documentation of medication management within a person's health record using medication charts (paper-based or electronic or a hybrid combination)?
- How does the RACF ensure that a person's medication chart is accurate, kept up-todate and remain secure and are only viewable by those with permission to view?

Guiding Principle 10: Medication reconciliation

Medication reconciliation processes are used within RACFs to:

- Verify a person's medication history
- Reduce the risk of errors in medicines documentation when care is transferred, or new medicines are prescribed
- Ensure all medicines are ordered and received as intended.

Summary and intent

For people receiving care in a residential aged care facility (RACF), medication reconciliation processes have been shown to:

- Reduce errors and adverse events associated with poor quality information at transitions of care between facilities, care settings and providers
- Reduce inaccurate documentation of a medication history when a person receiving care within a RACF is transferred to hospital.

Medication reconciliation ensures that a person recieves all the medicines intended by their prescriber.

A best possible medication history (BPMH) is considered the first step in a 'formal' medication reconciliation process. Medication histories are often incomplete, with medicines, strengths and doses missing, and complementary and self-selected non-prescription medicines often omitted (refer to Guiding Principle 7: Complementary and self-selected non-prescription medicines).

It is vital that the individual or their carer and/or family are actively involved and that the RACF has a formal, systematic process in place to support obtaining a BPMH.

To reduce the risk of transcription errors, omission, or duplication of therapy, a BPMH is obtained as soon as possible following admission or readmission to the RACF. At least two sources of information are required to obtain and then confirm (or verify) a person's BPMH. Examples include the person's:

- Current medicines list or My Health Record (including the Pharmacist Shared Medicines List)[66]
- Nominated medical practitioner or primary healthcare practitioner records
- Usual community pharmacist
- Most recent discharge summary or Aged Care Transfer Summary (ACTS).

Once the BPMH is documented and verified, it can be used to compare (or reconcile) the person's medicines orders and documented treatment plan to:

- Ensure continuity of medication management
- Identify medicines-related problems
- Identify potential medicines-related discrepancies (including omissions)
- Inform the decision-making process
- Optimise the safe and quality use of medicines.

If the medication reconciliation process identifies that changes are required to a person's medicines – for instance, a dose or regimen change – the prescriber documents these changes by updating the person's medication chart (paper-based or electronic) (refer to Guiding Principle 9: Documentation of medication management).

To support continuity of care, the verified BPMH information is communicated to the next care provider, and a person's own medicines-related records are updated (for instance, My Health Record or medicines list[53]).

Figure 5 summarises the key steps in the medication reconciliation process.

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.

Medication reconciliation

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

- Admission or transfer to the RACF from the community, hospital or other care setting
- Transfer from the RACF to the community, hospital or other care setting
- When existing medicines orders are changed or a new medicine is ordered
- When paper-based medication charts are rewritten or electronic medicine orders are updated
- Following a medication review.

Best possible medication history

A BPMH is a list of all the medicines that a person is currently taking. This includes all prescription, complementary and self-selected non-prescription medicines. The BPMH is a snapshot of an individual's actual medicine use, which may be different from information in their RACF record, in the medicines list[53] held by the person, or provided by their prescriber (such as their general practitioner) or pharmacist.

Figure 6 provides and overview of medication management and the close relationship between the BPMH and medication reconciliation, as well as medication review (refer to Guiding Principle 11: Medication review).

Figure 5: Key steps in medication reconciliation

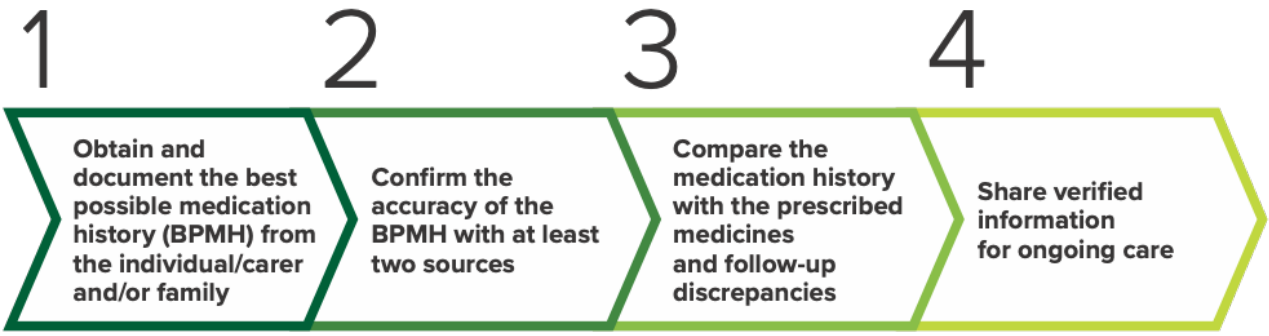
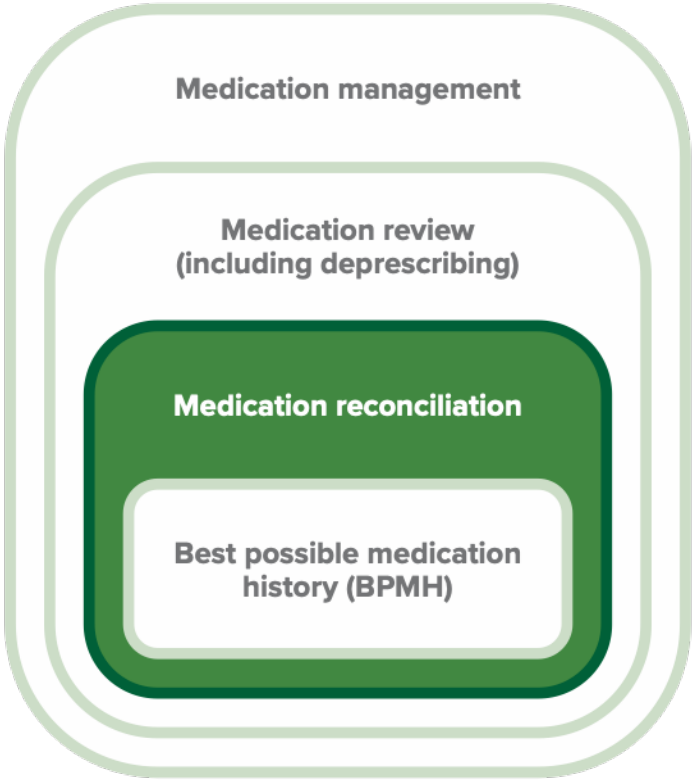


Figure 6: Overview of medication management



Implementation – key tasks and strategies

For the RACF

The RACF needs to have policies, procedures and guidelines in place to support medication reconciliation. These need to be endorsed by the medicines governance group (or MAC). They need to:

- Outline the range of health professionals that can complete medication reconciliation – for example, medical and nurse practitioners, pharmacists, registered nurses and other relevant healthcare providers
- Recommend that people who are newly admitted to the RACF
  - are encouraged to provide a list of their current medicines or bring their medicines when they are admitted, including complementary and non-prescription medicines
  - have their medicines reconciled upon admission
- Require the results of medication reconciliation to be documented in a standardised format in the person's health record (paper-based or electronic); this includes any changes and the reasons for each change
- Include the need for regular monitoring and evaluation of BPMHs and medication reconciliation use across the RACF.

The RACF needs to ensure that policies, procedures and guidelines for obtaining a BPMH include:

- A structured interview process for eliciting, recording and verifying a person's actual medicine use
- Key steps of the process and when they should occur (for example, upon admission to the RACF)
- Documentation requirements (where and what should be documented, such as use of a standardised form (paper-based or electronic)

- Roles and responsibilities of healthcare professionals – for instance, medical and nurse practitioners, pharmacists and registered nurses
- Education and training requirements for healthcare professionals
- Involvement of individuals and their carers and/or families (refer to Guiding Principle 1: Person-centred care and Guiding Principle 2: Communicating about medicines).

The RACF also needs to ensure that if medication reconciliation results in any changes to a person's medicines that there are processes in place for updating the person's medication chart and their own medicines-related records (for instance, My Health Record or medicines list[53]) (refer to Guiding Principle 9: Documentation of medication management).

Medication reconciliation also needs to be completed for individuals who self-administer their own medicines, when dose-administration aids (DAAs) are being used within the RACF and when pharmacists are preparing DAAs for a RACF.

For the healthcare workforce

Medical and nurse practitioners, pharmacists and registered nurses can take a BPMH and perform medication reconciliation.

Healthcare professionals need to ensure that the current list of medicines is accurately communicated each time care is transferred or medicines are reordered on a person's medication chart.

Guidance for medical practitioners on appropriate medication management practices can be found in the *RACGP aged care clinical guide (Silver Book)*.[48] This includes applying general principles of medication management[67] that consider 'all medications taken' by the person.

Guidance for pharmacists on medication reconciliation and the need to reconcile a person's medicines can be found in the Pharmaceutical Society of Australia (PSA) *Guidelines for comprehensive medication management reviews*.[68]

In addition, PSA *Guidelines for pharmacists providing dose administration aid services*[69] provide advice on medication reconciliation and creating an accurate medication profile prior to packing a DAA, when changes (including temporary changes during periods of acute illness) are made or when care is transferred. The Quality Care Pharmacy Program (QCPP) framework[70] and standards[28] also covers a range of requirements for DAA services.

To minimise the risk of errors – for example, inclusion of a ceased medicine – when administering medicines from a DAA, the contents need to be reconciled by the nurse against the person's medicines orders on their medication chart (refer to Guiding Principle 15: Administration of medicines by nurses).

When obtaining and verifying a person's BPMH, prescribers, pharmacists and registered nurses can access various sources – for instance, the person's medicines list[53], My Health Record, their discharge summary, another healthcare professional's records, or alternatively, if available, the person's ACTS.

Healthcare professionals may find it useful to use a checklist (Figure 7) to reduce the likelihood of omitting relevant details and improve the accuracy and completeness of the BPMH documentation.

Registered nurses and pharmacists need to inform the person's prescriber of any discrepancies they uncover so that, if necessary, the person's medication chart can be updated.

Figure 7: Example medication history checklist71

Medication history checklist

☐ Prescription medicines:

- ☐ Sleeping tablets
- ☐ Inhalers, puffers, sprays, sublingual tablets

☐ Non-prescription medicines (for example, OTC medicines)

☐ Complementary medicines (for example, vitamins, herbal or natural therapies)

☐ Analgesics

☐ Gastrointestinal medicines (for example, for reflux, heartburn, constipation or diarrhoea)

☐ Topical medicines (for example, creams, ointments, patches)

☐ Inserted medicines (for example, nose/ear/eye drops, pessaries, suppositories)

☐ Injectable medicines

☐ Intermittent medicines (for example, weekly)

☐ Recently completed courses of medicines

☐ Social and recreational drugs

☐ Other people's medicines

For the individual, their carer and/or family

An individual receiving care within a RACF needs to inform their prescribers, pharmacists and RACF registered nurses about all the medicines they are taking so that:

- An accurate history of a person's medicines is documented
- Avoidable errors (as a result of inaccuracies or incomplete details) are not made when medicines are prescribed, dispensed and/or administered.

It is important that the best possible medication history is available soon after admission to a RACF, or when a person is transferred back to a RACF. This will ensure that the prescribers, pharmacists and RACF registered nurses can check and reconcile the listed medicines against those prescribed on the medication chart.

The healthcare provider conducting the medication history interview will ask about and discuss any concerns a person has about their medicines. The person's answers may allow the interviewer to seek additional information, to gain a sense of the person's:

- Medicine-taking behaviours (including adherence to the dosage regimen, or whether they have any difficulty taking their medicines)
- Understanding of why they are taking certain medicines
- Perception of the effectiveness of their medicines
- Perception of potential adverse effects or allergies
- Understanding of monitoring certain medicines (for example, anticoagulants).

People who are newly admitted to the RACF should receive a comprehensive medication review – for example, a residential management medical review (RMMR) – upon admission (refer to Guiding Principle 11: Medication review).

The details of the medication history and reconciliation process will be documented, including any changes to a person's medicines (and the reasons for these changes), within the person's health record (paper or electronic) and reported to the person's primary healthcare provider – for instance, their general practitioner.

The more medicines a person takes, the more difficult it can be to remember everything about them. Keeping a person's medicines list up to date will ensure that everyone involved in the person's health care knows which medicines are being used. The prescriber, pharmacist or registered nurse will ensure a person's own medicines-related records such as the My Health Record and/or medicines list[53] are also updated.

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 does the RACF have in place to address medication reconciliation?
- What processes are used to obtain and record a person's BPMH?
- What processes are in place to ensure that healthcare professionals review the person's current medicines orders against the BPMH?
- How and where are discrepancies with a person's medicines documented and reconciled?
- How are changes to a person's medicines, and the reasons for change, documented and communicated to other healthcare providers, including at transfer of care?
- How does the RACF evaluate the quality of people's involvement in the process of obtaining a BPMH?
- How does the MAC monitor reconciliation processes at facility level?

Guiding Principle 11: Medication review

The RACF healthcare team and visiting healthcare providers ensure that each person's medicines are reviewed regularly and as needed, to optimise medicines use and minimise medicines-related problems.

Summary and intent

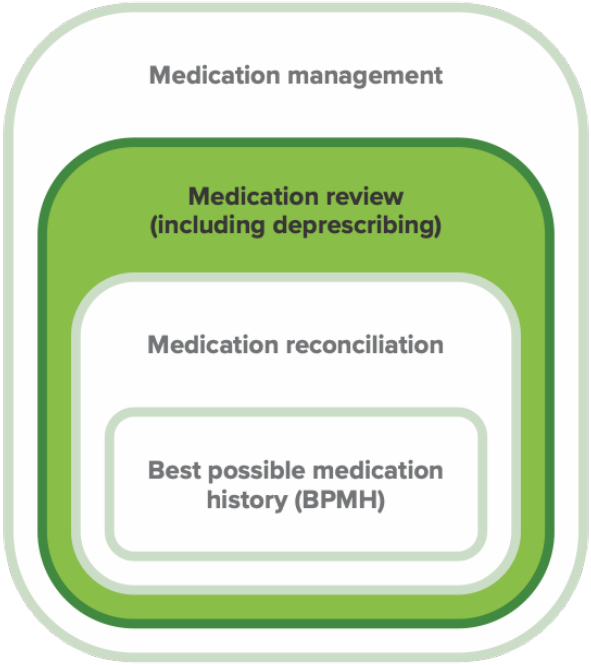
Importance of medication review

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

For a person receiving care in a residential aged care facility (RACF), regular medication review is important to make sure the person's medicines are being used safely and for the intended purpose, and to achieve the best possible experience and outcome. Medication review is related to but distinct from medication reconciliation. Figure 8 provides an overview of medication management and the close relationship between medication review and medication reconciliation (refer to Guiding Principle 10: Medication reconciliation).

Medication review is particularly important where there has been a significant change in a person's health status or medicines use – for instance, as a result of a recent hospital admission or an acute exacerbation of a chronic illness. Regular medication review is recognised as best practice in medical practitioner, nurse and pharmacist professional practice standards.

Figure 8: Overview of medication management



Collaboration

Medication review is intended to be collaborative and involve the person's medical practitioner, pharmacist, nurses and other relevant healthcare professionals. Although

medication review is considered an inherent role of a pharmacist, medicines should also be reviewed by healthcare professionals whenever decisions are being made about prescribing, dispensing and administering medicines.

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 each person in their care. If risks with medicines use are identified early, it may prevent unnecessary escalation in care or hospital admission.

Conducting a medication review

In conducting a medication review, comprehensive information about the person's use of medicines (including prescription, complementary and self-selected non-prescription medicines – refer to Guiding Principle 7: Complementary and self-selected non-prescription medicines) is collated and assessed. This can identify and meet medicines-related needs and uncover, resolve and prevent medicines-related problems, including inappropriate Poly-pharmacy. 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.

Medication reviews in RACFs

Information obtained from a medication review is documented to support development of an individualised medication management plan (MMP). An MMP is a communication tool detailing the intended goals of therapy along with follow-up actions or recommendations to optimise medicines use. It supports the sharing of information about a person's medicines between all relevant healthcare professionals and healthcare service providers involved in their care, especially at transitions of care (refer to Guiding Principle 2: Communicating about medicines).

Given their age and complexity, the focus within this Guiding Principle is on ensuring each person's medicines are regularly and comprehensively reviewed, and that this is a multidisciplinary and collaborative process. Residential medication management reviews (RMMRs) are designed to support individuals living and receiving care within RACFs, however, are limited according to eligibility and funding requirements.

People who are newly admitted to the RACF need to receive a comprehensive medication review – for example, an RMMR – as soon as possible after admission to the RACF.

Given the close relationship within the scope of medication management, Guiding Principle 11 should be read in conjunction with Guiding Principle 6: Selection of medicines and Guiding Principle 10: Medication reconciliation.

If, as a result of any follow-up actions or recommendations, changes are made to a person's medicines, these are documented by the prescriber on the person's medication chart (paper-based or electronic) (refer to Guiding Principle 9: Documentation of medication management).

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.

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 Poly-pharmacy is an issue
- The ability of the individual to take or use the medicine as intended.

The focus of a medication review is also on the person's health, independence, care and comfort and facilitating the best possible outcome from their medicines.

Examples of the circumstances that can trigger a medication review include:

- Transfer of care – for example, discharge from hospital
- Changes to the person's medicines regimen
- Change in medical condition, health status or abilities – including an acute illness, a fall, change in cognition or physical function, swallowing difficulties
- Prescription of high-risk medicines, for example, psychotropic medicines, as well as those with a narrow therapeutic index or requiring therapeutic monitoring – for example, anticoagulants or insulin
- Presentation of symptoms suggestive of an adverse drug reaction – including a suspected allergy
- Sub-therapeutic or lack of response to treatment
- Suspected non-adherence, or problems with managing medicines-related therapeutic devices – for example, metered-dose inhalers
- Risk of, or inability to continue administering own medicines – for example, due to changes in dexterity, cognition or vision.

Some of the circumstances described above would also prompt an assessment of a person's ability to safely self-administer their own medicines (refer to Guiding Principle 14: Self-administration of medicines).

Implementation – key tasks and strategies

For the RACF

The RACF needs to ensure that existing processes for medication review reflect and support a quality use of medicines (QUM) approach and that the processes:

- Determine who is responsible for conducting a medication review and making a referral for an RMMR
- Prioritise medication reviews for people who are most at risk of or have suffered a medicinesrelated problem – for example, people taking high-risk medicines such as psychotropic medicines, anticoagulants or insulins, or who have recently suffered harm from the use of a high-risk medicine
- Advise on how and where to document actions and recommendations as a result of a medication review – for instance, an individual medication management plan
- Identify and monitor trends in medicinesrelated problems, including those that have been prevented
- Promote partnership, communication and shared responsibility by all involved in medication review to achieve optimum health benefits and outcomes for people in their care.

The RACF needs to ensure that policies, procedure and guidelines are in place that:

- Outline the system and scope of medication review, which comply with national program rules, relevant state and territory legislation and are endorsed by the RACF's medication advisory committee (MAC)

- Outline the range of healthcare professionals that can conduct medication reviews – for example, medical and nurse practitioners, pharmacists, registered nurses and other relevant healthcare professionals
- Recommend that people newly admitted (or readmitted following hospital discharge) to the RACF, receive a comprehensive medication review – for example, an RMMR – as soon as possible after admission
- Specify the minimum number of medication reviews each person should receive within a defined period of time, based on their medicines-related risk profile – for example, anticholinergic drug burden index (DBI) and anticipated need for medicines monitoring and evaluation
- Identify the healthcare professional responsible for follow-up, implementing agreed strategies and monitoring the person's ongoing health status and medicines-related risk profile or DBI
- Require the results of a medication review to be communicated to the person's primary healthcare provider or general practitioner – for instance, a copy of the person's medication management plan (paper-based or electronic)
- Include the need for regular monitoring and evaluation of their use across the RACF.

The RACF also needs to ensure that:

- If medication review results in any changes to a person's medicines that there are processes in place for updating the person's medication chart and their own medicines-related records – for instance, My Health Record or medicines list[53], and for advising the individual and their carer and/or family of the changes
- Healthcare professionals have the knowledge, skills, competence and delegated regulatory and legal authority to conduct medication reviews, including comprehensive medication reviews
- Newly admitted individuals receive a comprehensive medication review – for example, RMMR – as soon as possible after admission, and
  - the RACF needs to refer to the Australian Government's RMMR program rules[34] for eligibility criteria, noting that comprehensive medication reviews are available to people who live permanently within Australian Government-funded RACFs
  - a person's informed consent[72] must be obtained.

For the workforce

When reviewing a person's medicines, healthcare professionals need to:

- Understand the person and their cultural, clinical, specific needs
- Understand the available treatment options, their implications and appropriateness
- Discuss and agree on a plan in partnership with the person, including the expected outcomes
- Review treatment response including adherence and/or the need to cease (for instance, deprescribe) a medicine or modify the dose of a medicine
- Consider if the person's medicines need to be reviewed more than once in a short period of time.

Prescribers need to consider any follow-up actions or recommendations following medication review. If any changes are to be made to a person's medicines, they must update the relevant medicines orders on the person's medication chart (refer to Guiding Principle 9: Documentation of medication management).

Guidance for medical practitioners on appropriate medication management practices can be found in the *RACGP aged care clinical guide (Silver Book)*.[48] This includes reviewing a person's medicines for inappropriate polypharmacy[49] and deprescribing.[43] Information on RMMR and other Medical Benefits Schedule item numbers[73] are also found in the RACGP Silver Book Part B.

Guidance for pharmacists on medication management reviews can be found in the Pharmaceutical Society of Australia (PSA) *Guidelines for comprehensive medication management reviews*[68], including information about the RMMR program rules.[34]

When conducting medication reviews, healthcare professionals need to consider:

- Is there a documented reason or evidence base for use of a medicine?
- Does the person still need the medicine?
- Is the medicine still working?
- Does the dose need to change?
- What risks are associated with use of the medicine, and what monitoring is required?
- Are there any person-specific issues that will affect use of the medicine?

A person's experience of using medicines and their own needs may change over time, especially during an admission to hospital. This means that a person's medicines needs to be reviewed (as well as reconciled – refer to Guiding Principle 10: Medication reconciliation) when care is transferred back to the RACF, and if required, multiple times thereafter.

For the individual, their carer and/or family

The need for a medication review for a person already receiving care can be identified by the person's prescriber, the pharmacist, RACF nurses or other healthcare professionals.

An individual receiving care, their carer, family and/or substitute decision-maker can also request for their medicines to be reviewed at any time by their medical practitioner or pharmacist. This includes requesting a comprehensive medication review – for example, RMMR.

People who are newly admitted to the RACF need to receive a comprehensive medication review – for example, RMMR – as soon as possible after admission. This is likely to also involve verifying and reconciling the medicines a person is currently taking (refer to Guiding Principle 10: Medication reconciliation).

However, the person's medical practitioner must assess the clinical need for an RMMR and determine that an RMMR is necessary and the person, or their decision-maker, must provide consent prior to the RMMR taking place. Consent is being given to disclose personal information such as Medicare number, name and date of birth.

The healthcare professional conducting the medication review will ask about and discuss any concerns a person has about their medicines, including the results of a person's medication review.

The details of the medication review will be documented – including any actions or recommendations in a person's individual MMP (or the person's health record or electronic equivalent) – and reported to the person's medical practitioner.

Resources

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

Reflective questions

- How does the RACF ensure that each person's medicines are regularly reviewed, and follow-up action(s) is taken where necessary?
- What policies, procedures and guidelines for medication review does the RACF have in place or available for healthcare professionals?
- How does the MAC monitor the use of medication review processes at facility level?
- What processes, tools or risk assessment criteria are used to identify individuals at risk of medicines-related problems or adverse events and prioritise them for medication review?
- How does the RACF engage the individual's family, their carer and/or their substitute decision-maker to assist the person during the process of a medication review?
- How does the RACF ensure that informed consent for a medication review is documented appropriately?

GUIDING PRINCIPLE 12

Guiding Principle 12: Continuity of medicine supply including in an emergency

The RACF minimises interruptions to medicines supply and maintains timely access to medicines for each person receiving care. This may include having access to a curated emergency stock of medicines.

Summary and intent

For a person receiving care in a residential aged care facility (RACF), continuity of medicines supply is maintained by the RACF to avoid potential adverse health outcomes from interruption or a sudden change in their medicines.

Interruptions in continuity of medicines supply have the potential to arise in several circumstances. Examples include where a person is:

- Prescribed a new medicine or an urgent change is made to the dose or formulation of their existing medicine
- Transferred from hospital or another care setting without a supply of medicines. This could include periods of respite care.

Medicines held and managed as emergency stock and the emergency supply of medicines in RACFs are subject to state and territory legislation. In some states and territories, RACFs are permitted to hold a limited range of medicines as 'imprest' stock for emergency use on the written or verbal order of a prescriber.

The emergency (or 'imprest') stock of medicines is available for urgent treatment by a registered nurse only when normal supply arrangements are not available. This is different to the authorised initiation of a medicine by a nurse, as described within Guiding Principle 8: Authorised initiation of medicines by nurses.

National and local medicines shortages can have immediate and long-term impacts on medication management across the healthcare continuum, including in RACFs. Excess purchasing and stockpiling of medicines can also lead to unusually high demand and impact to medicine availability.

The Therapeutic Goods Administration (TGA) publishes the Medicines Watch List[74] setting out all shortages that have a critical impact on people. Information about medium- or low-impact shortages may also be published where the manufacturers agree or if the TGA determines that it is in the interest of public health. The medicine shortage reports database[75] includes information about shortages of reportable medicines in Australia, including those arising from the discontinuation of products.

The TGA has information on accessing medicines during a shortage.[76] This includes access through Schedule 19A[77] whereby consumers can access products not listed on the Australian Register of Therapeutic Goods ('off label' use) during medicines shortages.

Any disruption to medicines supply may lead to adverse outcomes – including poor symptom control and unplanned hospital admissions.

Pre-emptive measures need to be in place to prevent impacts on continuity of medicines supply. In addition, policies, procedures, and guidelines need to outline how the RACF manages and responds where safe and quality use of medicines is potentially undermined by disruption to the continuity of medicines supply.

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.

Emergency stock of medicines

Medicines kept as 'imprest' stock for emergency or urgent use are only for access when normal supply arrangements are not available. Medicines from the emergency stock are only administered by registered nurses on the written or verbal order of a prescriber, such as a medical practitioner or nurse practitioner – for example, when a new medicine is prescribed and the community pharmacy which usually dispenses a person's medicines is closed.

If required, multiple doses may be administered by the registered nurse from the 'imprest' stock until the pharmacy can dispense the new prescription. The pharmacy that supplies the RACF needs to be notified when 'imprest' stock is used so they are able to organise replenishment.

In some states and territories, specific legislation or guidelines may apply. For example, in Victoria, RACFs can choose to obtain a health services permit, for which an annual fee must be paid.[78] The health services permit enables the RACF to obtain an 'imprest' supply of medicines that have not been prescribed for specific people, so that selected medicines are readily available for immediate administration by a registered nurse.

In New South Wales, medicines kept as emergency stock can include Schedule 4 and Schedule 8 medicines such as:

- Antibiotics in oral form
- Atropine sulfate monohydrate injection
- Diazepam injection 10 mg in 2 mL
- Morphine sulfate pentahydrate injection 5 mg in 1 mL.[79]

Medicines shortages

A medicines shortage occurs when the supply of a medicine in Australia is not likely to meet normal or projected consumer demand. Local supply disruptions are not medicine shortages but can still impact safe and quality use of medicines.

Maintaining fair and equitable access to medicines is integral to safe and quality care. Medicine supplies may be impacted for several reasons, including manufacture, financial viability, and problems within the global supply chain. Any resulting medicine shortage may directly or indirectly impact on the safe and quality use of medicines.

Implementation – key tasks and strategies

For the RACF

The RACF needs to ensure that medication management policies, procedures and guidelines are in place to support continuity of medicines supply for people receiving care, and that these:

- Are approved by the medication advisory committee (MAC) and comply with relevant state and territory legislation
- Aim to reduce the risk of omission of a critical medicine and the potential for admission or readmission to hospital
- Provide for continuity of medicines supply at transitions of care and medicines held in stock for emergency or urgent use.

The RACF needs to ensure that its policies, procedures and guidelines cover a range of circumstances, including when:

- A new medicine is prescribed or there is an urgent change to the dose or formulation of an existing medicine
- A person is transferred from hospital or another setting with limited or without a supply of medicines, including for respite care
- An individual is on short term or temporary leave – for example, a day outing
- An unexpected health outbreak occurs amongst people receiving care – for example, gastroenteritis[80]
- A person experiences an acute symptomatic illness, including exacerbation of a chronic illness – for example, an infection requiring urgent treatment with an appropriate antimicrobial
- Orders change for medicines packed in dose administration aids (DAA) or a DAA is required urgently, outside of the scheduled delivery period
- An unexpected medicine shortage occurs.

At transitions of care, the RACF needs to:

- Liaise with local healthcare services to support continuity of medicines supply at transitions between hospitals and the RACF
- Implement medication management systems to support continuity of medicines supply at transitions of care. This includes
  - use of Interim Residential Care Medication Administration Charts (where available in the state/territory) when individuals are discharged from hospital (refer to Guiding Principle 9: Documentation of medication management)
  - use of an electronic medication management system that is interoperable with My Health Record
- implementation and use of the electronic National Residential Medication Chart (eNRMC)[81]
- Ensure that the medication management system, eNRMC and the person's My Health Record are updated regularly so that the medicines are correct upon any clinical handover or transition of care.

Continuity of medicines supply

Strategies to support ongoing medicines supply, include:

- Service arrangements with pharmacies to manage
  - urgent supply of medicines
  - changes to a person's medicine order, including after-hours or interim supply
  - where there may be a time delay between new medicine orders and their supply in a dose administration aid (DAA)
- Organising in advance, sufficient supplies of appropriately packaged and labelled medicines for short-term or temporary leave – such as day outings – to individuals and/or their carers
- Adequate supplies of end-of-life medicines via anticipatory prescribing
- A secure 'imprest' or on-site medicines storage arrangement for stock of medicines for emergency or urgent use and end-of-life care (refer to Guiding Principle 13: Storage and disposal of medicines)
- Providing information to individuals and/or their carers about how to obtain further supply of medicines, if required – for example, on entering or leaving respite care
- Ensuring the person receiving care has an uptodate medicines list, such as My Health Record or medicines list.[53]

Emergency supply

The stocking of medicines for emergency supply must be in accordance with any state or territory legislation. Where there is state or territory legislative support for stocking medicines for emergency supply, only a minimal range of medicines should be stocked for urgent use

when normal supply arrangements are not available. For emergency or 'imprest' medicines, the MAC needs to determine:

- The list and quantity of medicines for emergency use that can be held by the RACF
- The circumstances under which the medicines may be used
- Who may access and administer the emergency or 'imprest' stock of medicines
- What documentation is required, including verification of a telephone order
- Processes for obtaining and maintaining the integrity of the stock; this includes appropriate storage, stock rotation, requirements for expiry date checking and processes for access, administration, recording and re-supply (refer to Guiding Principle 13: Storage and disposal of medicines).

Governance over the list of medicines held for emergency use is crucial, especially where inappropriate use can be of concern. For example, there must be appropriate governance for the use of antimicrobials in accordance with appropriate stewardship policies, procedures, and guidelines. This includes reference to:

- The Aged Care Quality Standards[15] (Personal care and clinical care)
- The latest *Therapeutic Guidelines: Antibiotic*[82] and other relevant resources such as *Antimicrobial Stewardship in Australian Health Care*[83]
- The latest chapter on Antimicrobial Stewardship in community and residential aged care.[84]

For the healthcare workforce

Shortages of prescription medicines and some over-the-counter medicines are reported by the TGA in the medicine shortage reports database.[75] For medicines in short supply, the database will provide an estimate of how long the medicines' shortage will last and may advise if there is an alternative medicine available.

In some situations, local-level supply disruptions can occur where a medicine is unavailable in a particular pharmacy or area. In many cases, this temporary disruption will be resolved quickly, and the RACF will be able to obtain the medicine once the pharmacy receives new stock. Sometimes local supply disruptions are caused by unexpected increases in demand for a medicine.

For the individual, their carer and/or family

Health professionals are experienced in determining suitable options when a medicine is in short supply or unavailable. These options, which need to be discussed, understood and agreed upon in partnership with the person's prescriber and/or pharmacist, may include:

- Supplying a different brand that contains the same active ingredient (which may not be the same dose form or strength)
- Prescribing a similar medicine to treat the condition
- Recommending a new treatment option for consideration
- Assisting the person to access their medicine through another pathway.[76]

Resources

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

Reflective questions

- What MAC-approved policies, procedures and guidelines does the RACF have in place to address and support continuity of medicines supply for all people receiving care?
- What policies, procedures and guidelines are in place for the management and access to an emergency stock of medicines approved for this purpose?
- How does the RACF ensure that its policies, procedures and guidelines for continuity of supply and holding of emergency stock of medicines are consistent with the requirements of relevant state or territory legislation?
- How do the policies, procedures and guidelines address the use and recording of emergency or ‘imprest’ stock and stock control maintenance?

GUIDING PRINCIPLE 13

Guiding Principle 13: Storage and disposal of medicines

The RACF ensures that:

- All medicines, including self-administered medicines, are stored and handled safely and securely, and in a manner that maintains the quality of the medicines
- Unwanted, ceased or expired medicines are disposed of safely to avoid accidental harm and misuse
- Disposal of medicines aligns with sustainable and environmental best practice.

Summary and intent

All medicines in a residential aged care facility (RACF) must be safely and securely stored. Medicines need to be handled with minimal waste and disposed of appropriately. This includes those managed and selfadministered by people receiving care.

The RACF's medication management policies procedures and guidelines need to support safe, and best practice, storage, handling and disposal of all medicines. They must include specific requirements for the safe storage, handling and disposal of cytotoxic medicines as well as opioids or Schedule 8 medicines, in accordance with the relevant state or territory legislative requirements.

Storage practices need to be in place to maintain the quality of each medicine, and storage conditions must follow the manufacturer's instructions on the packaging and within the medicine's product information (PI). This includes systems to maintain the integrity of temperature-sensitive medicines. Use of effective storage and cold-chain response systems ensure the integrity and efficacy of vaccines and other cold storage medicines.

Storage, handling and disposal of all medicines, including emergency (or 'imprest') stock and self-administered medicines, must be consistent with relevant state or territory legislation.

Principles for the safe selection and storage of medicines: Guidance on the principles and survey tool[85] 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 residential aged care settings.

Pharmacists can advise on safe and appropriate storage conditions, handling and disposal requirements for all medicines, including access to the Return Unwanted Medicines (RUM) Project[86] funded by the Australian Government Department of Health. The RUM Project ensures that unwanted medicines (including DAAs, inhalers and insulin pens) are disposed of in accordance with regulatory and state or territory environment protection authority requirements.

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.

Storage conditions

Generally, medicines should be stored in a cool (preferably below 25°C), dry and secure place.* Some classes of medicines and Schedule 8 medicines require special storage (including secure storage), handling and disposal requirements.

Special storage arrangements need to be in place for medicines requiring refrigeration (temperature-sensitive medicines), cytotoxic medicines and Schedule 8 medicines. These, and some other medicines, are not suitable for use in dose administration aids (DAAs) and are to be packaged separately. Refer to Guiding Principle 15: Administration of medicines by nurses, for additional information on DAAs.

1. Temperature-sensitive medicines

The National Vaccine Storage Guidelines – Strive for 5[87] is a useful resource for the RACF to refer to, for more details on what is required regarding the storage of temperature-sensitive medicines. The stability and effectiveness of some medicines – for example, some vaccines and insulin – require refrigeration to maintain integrity. Purpose-built refrigerators are recommended, and food must be stored separately from medicines – for instance, in a separate refrigerator.

* In accordance with the medicines' product information.

2. Cytotoxic medicines

Cytotoxic medicines must be:

- Stored and handled in accordance with the requirements of state or territory legislation
- Packaged and labelled separately, including specific cautionary and advisory labels
- Disposed of appropriately, with segregated provision for cytotoxic waste.

3. Schedule 8 medicines

Schedule 8 medicines must be separately secured and accounted for according to state and territory legislative requirements. This includes those governing the disposal of Schedule 8 medicines.

Disposal of medicines

Medicines that are used, unwanted, have been ceased or have expired need to be disposed of in a way that is safe and reflects best practice. Medicines disposal should be managed to ensure the safe and appropriate disposal of people's used, unwanted and expired medicines – including used topical patches, dose administration aids and other devices.* Cytotoxic medicines must be segregated and disposed of according to state or territory legislation. Unwanted and expired emergency 'imprest' stock and accountable (including Schedule 8) medicines held by the RACF also require mechanisms for authorised, appropriate and secure disposal.

* Devices include inhalers and insulin pens.

Implementation – key tasks and strategies

For the RACF

The RACF needs to:

- Establish appropriate governance and oversight to ensure that medicine storage systems are safe and inaccessible to the public, and the opportunity for diversion or theft is minimised
- Ensure that policies, procedures and guidelines for safe handling, storage and distribution of medicines all comply with state or territory legislative requirements, manufacturer's instructions and professional best practice for the
    - safe and secure storage, handling and distribution of medicines
    - storage of temperature-sensitive medicines and cold chain management
    - disposal of used, unused, unwanted or expired medicines
- Identify and reduce risks associated with medicines storage, handling and distribution, and develop and implement evidence-based procedures aimed at reducing these risks
- Audit compliance with policies, procedures and guidelines for the storage, handling and distribution of medicines
- Implement systems and purpose-built equipment to monitor and maintain the integrity of temperature-sensitive medicines
- Implement policies, procedures and guidelines for the disposal of used, unused, unwanted or expired medicines. Include details of how to minimise and segregate waste.

Storage provision must be designed, located and used to facilitate best practice. This includes use of lockable cabinets, medicines trolleys and medicines storage rooms within the RACF. It also includes provision of:

- Medicines storage for people who are selfadministering
- Storage of medicines-related equipment, such as syringes and needles
- Safety and security – such as preventing unauthorised access to medicines.

4. Risk identification

A risk assessment needs to be undertaken of the processes in place for the safe and secure storage, handling and distribution of medicines. Validated audit and risk tools will help identify and reduce risks associated with storage, handling and distribution of medicines within the RACF – for example, selected aspects of the assessment survey tool.[85]

Storage systems need to be evaluated for safety, quality and security risks, including the storage and delivery of accountable medicines, such as Schedule 8 medicines. Any evaluation should incorporate factors to identify the opportunity for 'look-alike, sound-alike' selection errors for medicines stored in close proximity. Look-alike, sound-alike medicines are captured in the National Tall Man Lettering List.[88]

5. Monitoring compliance

Compliance with processes for the storage, handling and distribution of medicines can be monitored using various methods, such as:

- Audits of compliance with policies, procedures and guidelines for the storage handling and distribution of medicines – for instance, temperature-sensitive medicines and separation of look-alike packaging
- Observation audits and walk-arounds to review security, workflow, workforce access, and approval processes for access to medicines storage areas
- Recording and reviewing incidents associated with storage, handling (including procurement) and distribution of medicines.

Corrective action is important when breaches, violations or practice variations are observed. Prompt review and reinforcement (including through education and training) of work practices helps to ensure safe and secure handling of medicines – for example, ensuring opioids are available only to healthcare professionals with authorised access.

6. Integrity of temperature-sensitive medicines

The RACF needs to review existing policies, procedures, and guidelines to ensure that there are effective systems in place for early detection and prompt response to problems such as refrigerator temperature excursions. Temperature excursions require timely management to prevent the integrity (safety, quality, potency and efficacy) of temperature-sensitive medicines and vaccines being compromised.

An effective approach to cold chain management includes:

- Audits of temperature control of storage facilities, including room temperature and refrigeration
- Regular testing and maintenance schedules for temperature alarms and temperature recording devices
- Purpose-built refrigerators for the exclusive storage of vaccines or medicines that require storage between 2 and 8°C
- Alarms to monitor refrigerators, as well as medicine storage areas where temperatures would ideally be maintained below 25°C
- Audible temperature alarms on refrigerators to provide an early warning in the event of a temperature excursion
- Details of action(s) required in the event of a cold chain breach or temperature excursion
- Education and training on cold chain management – for example, during nurse orientation or following a cold chain breach.

Specific guidance on vaccine storage is included in National Vaccine Storage Guidelines – Strive for 5.[87]

Specific resources are available for RACFs on the COVID-19 vaccine[89], including guidance for aged care service providers[90] and local guidance such as that provided by NSW Health.[91]

7. Disposal of used, unused, unwanted or expired medicines

Disposal methods need to be in place that avoid any risk of accidental poisoning, intentional or accidental misuse or environmental harm. This includes particular attention to:

- The additional risks to the workforce posed by vaccines, cytotoxics and other hazardous substances
- Equipment such as needles and syringes (or ‘sharps’)
- Legislative, health and safety, and state or territory requirements – for example, the secure disposal of recordable (Schedule 8) medicines only by those with the relevant authority, including safe disposal of used topical opioid analgesic patches
- Appropriate waste segregation – for example, the use of purpose-designed disposal bins such as, purple disposal bins for cytotoxics and Australian yellow sharps containers for needles and syringes
- Medicines disposal by or for people who are selfadministering
- Unused medicines due to a review of a person’s treatment plan.

It is important to consider and manage privacy issues in the disposal of unwanted medicines – such as information on medicine labels that identifies the person receiving care within the RACF.

8. Minimising environmental impact

Whilst medicines need to be disposed of safely and securely, there should be minimal environmental impact. The RUM Project[86] provides a free and safe method for the disposal

of unwanted and expired medicines and devices via any community pharmacy within Australia.

Specific requirements for waste segregation need to be in place that outline where special arrangements are required – for example, the handling and disposal of cytotoxic chemotherapy (and cytotoxic waste).

Minimising waste will also reduce the impact on the environment. Potential strategies include:

- Routine review of work practices that minimise waste and promote the safe and efficient use of medicines
- Consideration of prescription quantities based on the individual and their treatment to avoid oversupply
- Inventory management practices that eliminate wastage of medicines. For example, stock rotation and regular expiry date checking of emergency stock
- With their consent, disposal of a person's own medicines that were brought into the RACF and are not prescribed, required, or returned to them at transfer of care.

For the individual, their carer and/or family

Storage of expired and unwanted medicines can be dangerous and can lead to unintended poisoning.

Any medicines older than the expiry or use-by date must be disposed of.

The individual and their carer and/or family need to regularly review the medicines they keep for selfadministration for expired and unwanted medicines. They should:

- Check the expiry date on the label
- Alert the prescriber, nurse or pharmacist when medicines may no longer be needed; this may be prescribed medicines where the prescription has changed, or over-the-counter medicines no longer used.

A residential medication management review (RMMR) can assist. This can be requested by an individual receiving care within a RACF or their carer and/or family, and can be discussed with the person's medical practitioner (refer to Guiding Principle 11: Medication review).

Unsafe disposal of unwanted medicines can lead to environmental damage.

Medicines that have expired or are no longer needed can be either returned to the RACF nurse or directly to the community pharmacy for disposal. Consent can be provided to the RACF to dispose of unwanted medicines on a person's behalf.

The RUM Project[86] provides a free and safe method for the disposal of unwanted and expired medicines (including DAAs, inhalers and insulin pens). The pharmacist will use a secure RUM bin to store the medicines before they are safely disposed. Community pharmacies collect expired and unwanted medicines at no cost to the individual.

The Therapeutic Goods Administration (TGA) has developed consumer resources explaining why safe disposal of medicines is important[92] and how to access the RUM Project.

For the healthcare workforce

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

Healthcare professionals and care workers also have a responsibility to ensure medicines are stored and disposed of appropriately and in accordance with the RACF policies, procedures and guidelines and relevant state and territory legislative requirements.

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

Medicines return and disposal practices may also provide quality assurance feedback. For example, healthcare professionals should take the opportunity to monitor returned and unused medicines in dose administration aids (DAAs) which may assist in gauging an individual's adherence to treatment plans.

Guidance is available on specific storage and disposal requirements such as:

- National Vaccine Storage Guidelines – Strive for 5[87]
- Return Unwanted Medicines (RUM) Project.[86]

For instance, the RUM Project[86] ensures that unwanted medicines are disposed of in accordance with regulatory and state or territory environment protection authority requirements.

Particular care must be taken to ensure that sharp objects (or 'sharps') such as needles and syringes are also stored and disposed of safely. Sharp objects must not be collected under the RUM Project due to the danger of needlestick injuries to workers. All sharps must be placed in an appropriate purpose-designed bin – for instance, an Australian standard yellow sharps container – and disposed of separately according to local arrangements.

Resources

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

Reflective questions

- How does the RACF ensure that all medicines (including temperature-sensitive medicines) are stored and handled according to manufacturers' directions?
- How does the RACF manage and report risks associated with the storage of medicines?
- How does the RACF ensure that processes for medicines disposal are consistent with state or territory requirements?

GUIDING PRINCIPLE 14

Guiding Principle 14: Self-administration of medicines

The RACF:

- Supports and seeks informed consent from individuals who wish to administer their own medicines
- Ensures policies, procedures and guidelines are in place to guide the assessment and re-assessment of a person's capacity to self-administer medicines safely.

Summary and intent

Policies, procedures and guidelines, endorsed by the RACF's medicines governance committee (or MAC), need to be in place to support and provide guidance to healthcare professionals and other staff when medicines are to be self-administered by individuals receiving care.

To ensure there is no risk to themself or others, a person who wishes to self-administer their own medicines is to be formally assessed and supported, as part of achieving and maintaining maximum independence. Their informed consent must be obtained and documented.

No medicine is to be self-administered unless it has been ordered by a prescriber and dispensed by a pharmacist into an individual container or pack that is labelled with the person's name, the name and strength of the medicine and the dosage, frequency and route of administration.

Persons 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) – can assist or support a person to self-administer their own medicines. This could include, for example, taking the screw-cap lid off the person's medicine container or bottle, but not removing the scheduled medicines from the container.

Devices may be required to facilitate and support safe self-administration. The most common devices are dose administration aids (DAAs), and others, such as inhalers, spacers and pen devices, are also used. (For additional information on DAAs, refer to Guiding Principle 15: Administration of medicines by nurses.)

A person who manages their own medicines in residential aged care needs to know how to safely manage medicines, particularly during periods of acute illness. This includes during instances of acute exacerbations of a chronic illness. In these situations, changes to medicines administration, including withholding a medicine(s), may be required to minimise adverse drug events and/or admission to hospital. If necessary, a nurse will temporarily administer the person's medicines.

All self-administered medicines are documented on the medication chart (paper-based or electronic).

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. In a RACF, the person's consent must be obtained to do so.

According to the Quality of Care Principles 2014[93] care recipients '… retain their personal, civic, legal and consumer rights'. In addition, care recipients are to be 'assisted to achieve active control of their own lives' within residential aged care. The Aged Care Quality Standard 1: Consumer dignity and choice[22] also underpins a person's right to choose and be supported.

This includes the right for a person to choose to manage and administer their own medicines, including prescription, complementary and nonprescription medicines. This responsibility can be important for the person in maintaining a level of independence and control over making choices about their care.

However, a person who wishes to administer their own medicines, needs to be formally assessed to determine whether there is a risk to them self or others, including the person's capacity to self-administer medicines safely.

Regular review or reassessment of a person's willingness and ongoing capacity to self-administer their medicines is required, at a minimum of six monthly, especially when there is a change in health or cognitive status. For instance, during periods of acute illness, such as gastroenteritis or diarrhoea, a nurse may be required to temporarily manage and administer medicines for these individuals.

Dose administration aids (DAAs)

The most appropriate DAA for the person who is self-administering is likely to differ from that used by the RACF for other people receiving care. However, any DAA packing system that is utilised by the RACF is required to meet expected standards[69] and guidelines.[94]

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

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.

However, only solid oral medicines intended for routine use can be packaged in this way. Some solid oral 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 additional information on DAAs, refer to Guiding Principle 15: Administration of medicines by nurses.

Implementation – key tasks and strategies

For the RACF

The RACF needs to:

- Provide the option for individuals to selfadminister their medicines when they are assessed to be capable and safe for them to do so
- Ensure that policies, procedures and guidelines, endorsed by the RACF's MAC, are in place to support and provide guidance to prescribers, nurses and other staff when medicines are to be self-administered by individuals including
  - assessment and re-assessment of a person's capacity to administer their own medicines safely
  - obtaining consent to self-administer
  - obtaining consent to use a DAA
  - information on the management of medicines during periods of acute illness, including acute exacerbations of a chronic illness
- Ensure that an appropriate healthcare professional(s) is involved and responsible for performing the required assessment(s) on individuals who wish to self-administer their medicines – such as a medical practitioner, nurse practitioner, pharmacist or registered nurse; allied health professionals – such as an occupational therapist – could also have a key role when assessing and enabling an individual to engage in meaningful and productive tasks or activities, including self-administration of medicines
- Ensure that the storage and disposal of selfadministered medicines is consistent with the requirements of Guiding Principle 13: Storage and disposal of medicines and related RACF policies, procedures and guidelines
- Ensure that the medicines a person is selfadministering are not accessible to other people within the RACF, including visitors.

The RACF needs to:

- Have information on the assessment, reassessment and consent process for people who want to administer their own medicines
- Have information on the assessment and consent process for DAAs and ensure a person's consent is obtained to have their medicines administered from a DAA
- Ensure that the individual receiving care and their carer and/or family are aware of how to administer medicines from DAAs, and that there is regular medication reconciliation, and monitoring and follow up of each person using DAAs
- Ensure that the individual, their carer and/or family are aware of changes required to medicines administration during periods of acute illness.

9. Self-administration of medicines

Medication management policies, procedures and guidelines need to be consistent with national, state or territory legislative requirements – including that care workers (however titled) can assist people with their self-administration of medicines.

Policies, procedures and guidelines for self-administration of medicines (including Schedule 8 medicines) include information and guidance on:

- An individual risk assessment
- Obtaining or ordering medicines
- Recording of self-administration, especially if support is required
- Assisting people to take their medicines, if necessary
- Monitoring adherence (including individuals using a DAA)
- If a DAA is being used
  - reconciling the contents against the person's medicines orders

    - organising changes to the DAA, including during periods of acute illness*
- Storage of medicines – noting that whilst a person needs to have access to their medicines when required, the medicines a person is self-administering must not be accessible to other people within or who visit the RACF
- Disposing of unwanted (including expired) medicines.

Self-administration can vary from person to person and an individual risk assessment, underpinned by 'dignity of risk', will identify how much support is required to ensure a person is able to manage and administer their own medicines.

For the healthcare workforce

10. Assessment for self-administration

As outlined in the RACF's policies, procedures and guidelines for self-administration of medicines, healthcare professionals need to ensure consideration is given to a person's choice and whether there is a risk to themselves or others. This includes:

- An assessment of a person's capacity to self-administer medicines safely – for instance, using a 'dignity of risk' plan approach
- Regular review or reassessment of a person's willingness and ongoing capacity to self-administer their medicines, especially when there is a change in health or cognitive status.

Assessment needs to consider:

- The person's choice and right to make their own decision, such as choice of pharmacy service
- Involvement of the individual's carer, family and/or substitute decision maker
- If self-administration will be a risk to them self or other people
- If they can take the correct dose of their own medicines at the right time and in the right way – by considering, 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 consumer medicine information (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
    - the person's ability to comply with the safe and appropriate storage (and disposal) of self-administered medicines – including those that require refrigeration or other special storage conditions, such as Schedule 8 medicines (refer to Guiding Principle 13: Storage and disposal of medicines).

Other points to consider include:

- If the person **only wishes to self-administer some of their medicines**, such as oral dose forms, and have other forms such as eye drops, or injections administered by a registered nurse (refer to Guiding Principle 15: Administration of medicines by nurses)

* The identification of DAA packed medicines which require cessation or temporary dose adjustment – for example, in periods of acute illnesses – is to be undertaken by a registered nurse, prescriber or pharmacist, to allow for temporary dose adjustment or cessation. When this is not possible, a new DAA with the temporarily adjusted medicine needs to be supplied in a timely manner by the contracted DAA service provider or pharmacy.

- How often to repeat or review the assessment, for instance, based upon the person's need (for example, during an acute illness)
- How the medicines need to be stored
- Obtaining the person's informed consent
- The responsibilities of the RACF registered nurse, which can be documented in a person's care plan – including how a person's adherence will be monitored.

The registered nurse responsible for coordinating and conducting risk assessments needs to:

- Consult with the prescriber and pharmacist
- Discuss the requirements for self-administration of medicines with the person being cared for, including the correct storage of medicines, and the need for regular assessment
- Ensure there is a documented plan in place, which is discussed and agreed with the person, to manage their medicines during periods of acute illness. This may include the need to temporarily:
  - increase or decrease the medicine dose
  - cease the medicine
  - have a nurse administer their medicines
- Ensure the person has an accurate, current and complete list of their medicines, including complementary and self-selected non-prescription medicines (refer to Guiding Principle 7: Complementary and self-selected non-prescription medicines) and those medicines that are to be administered by a nurse (for example, injections).

The registered nurse also needs to:

- Record in the 'Considerations' section of the person's paper-based medication chart – for instance, the NRMC, or within an equivalent section of the eNRMC – that they will selfadminister their medicines along with other details, such as the date of the risk assessment
- Indicate alongside each charted medicine if the person is self-administering all or some of their medicines
- If required, assess and make arrangements for the most appropriate DAA for use by any person who needs support when self-administering their medicines; this DAA is likely be different to those used for others who are not self-administering their medicines
- Repeat the person's risk assessment at regular intervals and as required, including their ongoing ability to safely and effectively manage a DAA – for instance, if there is a change in the person's physical or cognitive status, and during periods of acute illness or acute exacerbation of their chronic illness ('sick days').

If a DAA is to be organised, the registered nurse in collaboration with the pharmacy provider needs to explain and confirm with the person:

- Which medicines they consent to be packed in the DAA
- Commencement date of the DAA
- How to use the DAA, and if assistance is required
- How DAAs will be managed during periods of acute illness, including assistance from a nurse to administer their medicines
- The need for ongoing assessment of their use of a DAA
- Any additional costs associated with DAAs, including if a new or replacement DAA is required.

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.

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 medicines orders on

their medication chart (refer to Guiding Principle 10: Medication reconciliation). This needs to be completed in a timely manner, especially for a person receiving a DAA for the first time and to ensure continuity of medicines supply. A DAA reconciliation also needs to be conducted at the time a residential medication management review (RMMR) is completed, including assessing or reassessing the continuing requirement for use of a DAA (refer to Guiding Principle 11: Medication review).

For the individual, their carer and/or family

People are supported to have an active role and make choices and decisions about their care, including the administration of their own medicines. This will involve a formal assessment by a registered nurse (in consultation with the prescriber and pharmacist) of their ability to do so and includes receiving and discussing information such as:

- Medicines self-administration policies, procedures and guidelines
- Assessment (and re-assessment) of the person's capacity, willingness and ability to self-administer their medicines, including when there is a change in health or cognitive status
- Appropriate storage of medicines
- The consent process for self-administration as well as the use of and administration from DAAs (including any associated cost).

Where individuals have 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. Other supports could include:

- Assistance to manipulate medicine containers – for instance, loosening or removing the lid
- Electronic reminders or alarms
- Larger font on dispensed medicines labels
- Help measuring liquid medicines or administering eye drops
- Information on a person's medicines – for instance, consumer medicines information (CMI).

A current record of whether a person has taken their medicines helps the individual, RACF registered nurses, pharmacists and the person's prescribers maintain an accurate record of self-administration. The healthcare professional assisting the person will record the self-administration on the person's behalf in the relevant section of the medication chart.

People who self-administer medicines are provided information and guidance on medicine administration during periods of acute illness, including:

- That some of their medicines may increase the risk of an adverse drug event
- If appropriate, when and how to temporarily adjust, or stop and restart medicines
- The potential need for a nurse to temporarily administer their medicines.

People who self-administer their medicines should hold a current record of their medicines, such as a 'patient medication profile', MediList or medicines list.[53] They need to inform their visiting or primary healthcare provider (for instance, their general practitioner), pharmacist and RACF registered nurse of all medicines they are taking and will be supported to maintain an accurate record of self-administration. A person should not self-administer any medicines that are not documented on their medication chart (refer to Guiding Principle 9: Documentation of medication management).

When a person is receiving short-term respite, they should receive the same care as that provided to others receiving care within the RACF. This includes supporting a person to self-administer their own medicines.

In addition and depending upon the goals of care and level of independence at home, a person receiving short-term respite should expect to maintain their medicine-taking skills. However, if the person was able to manage their own medicines at home and their level of independence changes whilst in the RACF, this might necessitate being assessed to be capable of self-administering their medicines for when they return home.

Resources

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

Reflective questions

- How are people assessed for suitability to self-administer their medicines?
- What is the process for the recording of administration of medicines for individuals who are self-administering?
- What is the process for the review of a person self-administering their medicines?
- How are people in residential aged care supported to administer their own medicines and maintain an up-to-date list of their medicines?
- How does the RACF ensure that care workers (however titled) who are assisting people to self-administer their medicines are appropriately trained and competent to do this?
- In practice, what is the process for the storage and disposal of self-administered medicines (including DAAs and other devices)?
- What is the process for assessing an individual's suitability and capacity to use a DAA?
- What information is provided to an individual, their carer and/or family about:
  - Medicines 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
  - The assessment and consent process for self-administration and use of DAAs

- The management of an acute illness (including exacerbation of a chronic condition)?

❖ How does the RACF ensure that information provided to an individual who wishes to administer their own medicines meets their needs?

❖ How is self-administration of medicines documented on the paper-based or electronic medication chart?

Information for respite care

❖ What information about the self-administration of medicines is provided to an individual, their carer and/or family who are being cared for temporarily as a result of admission for respite care?

❖ How does the RACF ensure that a person receiving respite care is supported to maintain their medication-taking skills, especially if they have been self-administering their own medicines at home?

GUIDING PRINCIPLE 15

Guiding Principle 15: Administration of medicines by nurses

Each RACF ensures it has policies, procedures and guidelines in place that are endorsed by the RACF's MAC, to guide the safe and effective administration of medicines by appropriately qualified and authorised nurses.

Summary and intent

Policies, procedures and guidelines, endorsed by the residential aged care facility's (RACF) medication advisory committee (MAC) need to be in place to support and provide guidance to those involved in the administration of medicines for medicines:

- Administered to individuals – including those in 'respite care'
- Administered from dose administration aids (DAAs)
- Altered prior to oral administration – for instance, to a person with swallowing difficulties
- Temporarily adjusted, in the event of an acute illness.

National, state and territory legislation and regulation, and relevant professional standards and guidelines govern medicines administration roles, responsibilities and practice by nurses.

Registered nurses and enrolled nurses, under the supervision and delegation of registered nurses, are responsible for the administration of medicines in RACFs. A registered nurse is the most appropriate person to manage the medicines dose schedule or regimen for a person receiving care within residential aged care.

Registered nurses are educated to:

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

The Australian Nursing and Midwifery Federation (ANMF) *Nursing Guidelines: Management of Medicines in Aged Care*[95] provides support and direction for registered and enrolled nurses in the administration of medicines in RACFs.

All medicines administration needs to be documented by the nurse administering the medicine (refer to Guiding Principle 9: Documentation of medication management).

Devices may be required and used to facilitate safe administration and/or self-administration. Whilst DAAs are the most common devices, others such as inhalers, spacers and pen devices are also used.

Medicines in DAAs may include prescription, complementary and non-prescription medicines. Only solid oral medicines intended for routine administration can be packaged in this way. In addition, 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 (refer to Guiding Principle 13: Storage and disposal of medicines). For instance:

- PRN medicines must be packed separately
- Cytotoxic medicines must be packed separately with appropriate cautionary labels

- Temperature-sensitive medicines may need to be packed separately and stored in the fridge
- Schedule 8 medicines must be packed separately and securely stored according to national, state or territory legislative requirements.

Some people suffer from swallowing difficulties, making administration of solid oral dose forms of medicines difficult. However, wherever possible, solid oral dose forms of medicines should not be altered or crushed, and alternatives should be sought – for instance, replace with dispersible tablets or liquid preparations, or use an alternative method of administration (via injection or dermal patch).

Registered nurses know how to safely manage medicines, particularly during periods of acute illness, including acute exacerbations of a chronic illness. Registered nurses use clinical judgement to assess whether medicines should be administered or withheld with regard to the person's health and family history, diagnosis, co-morbidities and health status.

Changes to medicines administration, including withholding a medicine(s), may be required to minimise adverse drug events and/or admission to hospital.

(Refer to Guiding Principle 14: Self-administration of 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 (refer to Guiding Principle 14: Self-administration of medicines).

Dose administration aids (DAAs), discussed below, are widely used in RACFs to assist with administration of medicines by nurses.

Dose administration aids

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

DAAs are designed to assist medication management for nurses administering medicines within RACFs, by having medicines divided into individual doses and arranged according to the dose schedule or regimen throughout the day. DAAs are used to improve efficiency and support safe and accurate administration of medicines.

Selecting the most appropriate DAA for the person self-administering and the RACF, noting these may not be the same type of DAA, will facilitate safe and high-quality care. Any DAA packing system that is utilised at the RACF is required to meet expected standards[69] and guidelines.[94]

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)[47] 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.

Swallowing difficulties

Swallowing difficulties are common in people receiving care in RACFs. A person thought to have swallowing difficulties needs to be screened for the risk of dysphagia before they are administered food, drink or oral medicines. Some medicines – for instance, anticholinergics – are known to cause swallowing problems and may increase the risk of choking.[96]

Alteration of oral dose forms

Alteration of oral dose forms is common in aged care, with crushing of oral tablets the most common alteration.[41] 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.

Implementation – key tasks and strategies

For the RACF

The RACF needs to:

- Ensure safety and high quality care for people receiving care is supported by medicine administration by nurses in accordance with national, state and territory legislation and regulations, and professional standards and guidelines such as the Australian Nursing and Midwifery Federation *Nursing Guidelines: Management of Medicines in Aged Care*[95]
- Ensure that policies, procedures and guidelines, endorsed by the RACF's medicines governance group or MAC, are in place to support and provide guidance to healthcare professionals and other staff when medicines are to be
  - administered to individuals
  - administered from DAAs
  - altered prior to oral administration, for instance, to a person with swallowing difficulties
- Include information on the management of medicines during periods of acute illness, including acute exacerbations of a chronic illness within the various administration-related policies, procedures and guidelines
- Ensure that an individual receiving care, their carer and/or family are aware of changes required to medicine administration during periods of acute illness
- Provide information on the assessment and consent process for DAAs and ensure a person's consent is obtained to have their medicines administered from a DAA.

The RACF needs to also:

- Establish policies, procedures and guidelines for DAAs that include
  - ensuring packaging quality and integrity; DAAs use tamper-evident packaging features that show if the container has been accessed before the medicine has been administered
  - monitoring for deterioration of medicines – for instance, changes in colour or disintegration
  - reducing risks to infection control from the re-use of soiled non-disposable components of DAA packs – for instance, plastic covers
  - the regular monitoring and review of DAAs for errors in labelling, packing and administration
- Provide information on the assessment for swallowing safety of medicines before being administered, and the referral process for people suffering swallowing difficulties – for instance, referral to a speech pathologist; this information needs to

include details about the process and who is responsible for reassessment or regular review
- Ensure that nurses administering medicines know 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
- Ensure evidence-based resources are available to healthcare professionals on the suitability for oral dose forms of medicines to be altered or crushed
- Ensure that nurses are currently registered and that enrolled nurses are appropriately qualified and authorised to administer medicines, and that administration practices are monitored for safety and quality and in accordance with the RACF's medicine administration policies, procedures and guidelines
- Use ongoing quality improvement activities such as education and training, developed in consultation with the MAC, to support appropriate medicines administration, monitoring and reporting practices (refer to Guiding Principle 3: Clinical governance of medication management and Guiding Principle 4: Evaluation and quality improvement in medication management).

Administration-related policies, procedures and guidelines ensure safe, quality medicines administration practices and must be consistent with:

- National, state or territory legislative requirements – including the categories of workforce that can administer and/or assist with the administration of medicines and the circumstances under which registered nurses can delegate medicine administration tasks to appropriately educated, and competent and authorised enrolled nurses
- Professional practice standards and guidelines
- Evidence-based best practice – for instance, clinical or therapeutic guidelines.

Administration-related policies, procedures and guidelines address:

- Review and reconciliation of medicines including changes to DAAs
- 'Rights of medication administration' such as
  - identification of the person in care
  - checking the medicine, the dose and route of administration
  - the time for administration
- Checking for allergies and adverse drug reactions
- Recording of medicines administration
- Monitoring and recording of effects of medicines
- Reporting of medication errors, incidents and adverse drug events – including those related to the use of DAAs
- Special requirements for administering 'high risk' medicines such as those with a narrow therapeutic index or at risk of misuse or abuse
- Appropriate administration practices – for example, use of oral and injectable forms, ointments, drops, inhalers, and nebulisers
- Alteration of oral dosage forms for people with swallowing difficulties – such as crushing tablets, and correct use and maintenance of crushing equipment or tools
- Arranging the most appropriate dose administration aids or other devices.

They also need to consider:

- Assessment and timely referral of those with swallowing difficulties to their primary healthcare practitioner and a pharmacist
- Escalation of care, including management of medicines during periods of acute illness, which may include the need to temporarily
  - increase or decrease the medicine dose
  - cease the medicine
  - administer the person's medicines (refer to Guiding Principle 14: Self-administration of medicines)

- Education and training requirements to support safe and effective administration of medicines
- Information needs of individuals receiving care and their carer and/or family.

11. Alteration of oral dose forms

The RACF needs to make the Australian SHPA *Don't Rush to Crush*[97] publication, available and accessible for registered nurses, pharmacists and prescribers to refer to when considering the need to alter an oral dose form. RACF procedures need to address:

- The requirement to adhere to the 'do not alter' instruction for the relevant medicines
- Awareness of the potential risks and effects on safety and efficacy of a medicine when the oral dose form is altered
- The appropriateness of the medium – for example, liquid – if any, in which the crushed medicine is dispersed and any impact on the medicine's efficacy
- Appropriate ways to administer crushed medicines – such as using an appropriate type and amount of fluid to help the person swallow the medicine, and ensuring the total prescribed dose is administered
- The acceptability of the altered presentation to the individual
- Risks of medicines contamination and infection control in the use of crushing and administration equipment and tools.

The RACF also needs to consider the education and training requirements for the healthcare workforce. Resources such as the NDIS Quality and safeguards Practice Alert; Medicines associated with swallowing problems[98] highlight medicines that can cause swallowing problems, and may increase the risk of choking during meal times. This resource may be useful and could be utilised to educate and inform nurses, pharmacists and prescribers, as well as people receiving care, of medicines that may exacerbate or cause swallowing problems. Examples include benzodiazepines which can make people drowsy, and anticholinergic antipsychotics that can cause dry mouth.

The RACF could engage the QUM pharmacist to provide education and training on the alteration of oral dose forms of medicines and about medicines that can cause swallowing difficulties.

12. Medicine administration during periods of acute illness ('sick days')

The RACF's policies, procedures and guidelines on medicine administration during periods of acute illness need to provide guidance on how to manage the medicines of individuals who self-administer medicines. This may include the need for the registered nurse to temporarily administer a person's medicines during their acute illness.

The identification of DAA packed medicines which require cessation or temporary dose adjustment, for example, in periods of acute illnesses, needs to be undertaken by a registered nurse, prescriber or pharmacist, to allow for temporary dose adjustment or cessation. When this is not possible, the RACF will need to organise supply of a new DAA with the temporarily adjusted medicine in a timely manner from the contracted DAA pharmacy.

13. Dose administration aids (DAAs)

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 administered.

RACF policies procedures and guidelines for DAAs need to consider:

- Their use by individuals for self-administration (refer to Guiding Principle 14: Self-administration of medicines)
- Who can administer from a DAA and the suitability of oral dose forms of medicines to be packed in a DAA

- Managing changes to medicines packed in DAAs 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
- Taking action when a problem or error is identified – for instance, returning a DAA to the preparing pharmacy for replacement.

14. Monitoring and reporting on the utilisation and quality of DAAs

The RACF needs to ensure that the DAA systems performance is regularly monitored, reviewed and reported to the medicines governance group or MAC as part of continuing quality improvement activities in medication management. This needs to include systematic reporting of packing or labelling errors (refer to Guiding Principle 3: Clinical governance of medication management and Guiding Principle 4: Evaluation and quality improvement in medication management). The following are examples of packing errors that can occur and should be monitored:

- 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.

15. Medication reconciliation and DAAs

Medication reconciliation needs to occur in a regular and systematic way, for all individuals using a DAA, including those receiving a DAA for the first time and those self-administering. This needs to be outlined within the RACF's policies, procedures and guidelines related to the administration of medicines as well as medication reconciliation (refer to Guiding Principle 10: Medication reconciliation).

16. Preparation of DAAs

DAAs can be prepared by community pharmacists and by external providers, who provide 'remote' automated dose-packaging (for example, sachet) systems. Irrespective of the service provider, DAA packing systems are required to meet expected standards[69] and guidelines[94] as well as relevant state or territory legislation. Whilst timely and accurate communication is needed about medicines to be packaged in DAAs, the RACF's policies, procedures and guidelines need to consider:

- Whether unit dose or multi-dose packs are appropriate
- 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 (refer to Guiding Principle 12: Continuity of medicine supply including in an emergency)
- 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 dosepackaging – for example, sachets
    - which include medicine 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.

In addition, the RACF's policies procedures and guidelines on DAAs need to address how a person's medication management needs will be met where:

- Medicines need to be packed across multiple DAAs – for example, for a short course of treatment with an antimicrobial

- Medicines need to be administered in specific ways in relation to food – such as before, during or after a meal
- There are irregular dosing schedules – for example, on alternate days or once a week
- The dosing schedule is more frequent than usual – for example, medicines for Parkinson's Disease
- There are medicines that cannot be packed with other medicines in a DAA – for example, cytotoxic medicines or 'as required' (PRN) medicines.

For the healthcare workforce

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 documented on the medication chart (paper-based or electronic).

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 (Poly-pharmacy), adverse drug events, medication errors and medication incidents.

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 labelled with the person's name, the name and strength of the medicine and the dosage, frequency, and route of administration.

The only exceptions are for nurse-initiated medicines or from a medicine treatment protocol (sometimes referred to as a 'standing order'), given in accordance with legislative regulation and organisational policy (refer to Guiding Principle 8: Authorised initiation of medicines by nurses).

Persons other than registered nurses or enrolled nurses, such as enrolled nurses not authorised to administer medicines, or assistants in nursing care workers (however titled), may only assist or support a person to self-administer their own medicines (refer to Guiding Principle 14: Self-administration of medicines). However, in some instances, assistants in nursing or care workers (however titled), can perform medicines-related tasks in accordance with state or territory legislation, regulations and RACF policies and procedures for delegation and supervision. This should include the level of training, skills and competence required to complete those tasks. Registered nurses have the responsibility to oversee these care workers (however titled).

Registered nurses, pharmacists and prescribers need to ensure relevant information about the administration of medicines is provided and discussed with the person receiving care. This information includes:

- 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 13: Storage and disposal of medicines and Guiding Principle 14: Self-administration of medicines)
- The assessment and consent process for use of and administration from DAAs
- The assessment for swallowing safety of medicines before being administered, and the referral process for people suffering swallowing difficulties
- When the dose or form of an oral medicine needs to be changed or altered (for instance, crushing a tablet), and the risks associated with altering the oral dose form of a medicine; this includes referring to the Australian SHPA *Don't Rush to Crush*[97] publication, as well as instructions on medicines packaging and DAAs, and in consumer medicines information (CMI) that indicates if the form is not to be altered (for example, 'do not crush or chew').

Registered nurses:

- Ensure medicines are administered in accordance with national, state or territory legislation and regulation, relevant professional practice guidelines, including the Australian Nursing and Midwifery Federation *Nursing Guidelines: Management of Medicines in Aged Care*[95], and the RACF's medicine administration policy
- Who administer medicines from DAAs, take responsibility for identifying each individual medicine prior to administration according to the ANMF Position Statement – The use of dose administration aids[99]; this includes checking that the DAA has not been tampered with or if a medicine has changed or deteriorated – for example, has changed colour or disintegrated
- Should report any incidents relating to the administration of medicines to the medicines governance group or MAC – including incidents related to DAAs
- When required, screen people thought to have swallowing difficulties for the risk of dysphagia before they are given food, drink or oral dose forms of medicines. If necessary
    - a timely referral to the person's primary healthcare practitioner and a pharmacist for review of their medicines is arranged
    - a dietitian, speech pathologist and/or an occupational therapist is involved
- Should refer to the latest edition of the Australian SHPA *Don't Rush to Crush*[97] publication for detailed information and guidance about alteration of oral dose forms of medicines
- If necessary, escalate care during periods of acute illness (or 'sick days') and in consultation with the person's medical practitioner and a pharmacist, arrange modifications to the person's medicines to decrease the risk of an adverse drug event.

17. Assessment of swallowing difficulties

Wherever possible, oral dose forms of medicines should not be altered (refer to the following section, 'Alteration of oral dose forms'). Before deciding to alter a dose form, the registered nurse, prescriber and pharmacist need to consider:

- The reason the person is unable to swallow the medicine in its usual form, and any therapy that may assist, including medicines that can be associated with swallowing problems such as anticholinergics
- Whether the person is ordered any medicines that should not be modified
- Whether the medicine is still indicated
- If there are alternative forms/formulations available
- If there are alternative medicines available.

If administration of an oral dose form of a medicine is an issue, the prescriber will need to order an alternative medicine or different formulation of the medicine.

Alternative formulations that may be available include dispersible tablets, liquids, topical applications, patches, intranasal sprays, suppositories, injections or stable extemporaneous mixtures.

18. Alteration of oral dose forms

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.

It is also important to ensure the crushed medicine can be swallowed easily and that adequate fluid is given with altered dose forms to aid ingestion.

Equipment or tools used for crushing or mixing a medicine need to be cleaned properly between medicines. 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 example, if a person is allergic to a medicine such as penicillin).

19. Medicine administration during periods of acute illness ('sick days')

For some medicines and some chronic conditions or comorbidities, the risk of adverse events may increase during periods of acute illness.[47] Modifications may need to be made to the use of some medicines to decrease this risk. This may include temporarily adjusting the dosage of a medicine or withholding a medicine, in consultation with the prescriber and pharmacist.

Acute illnesses that can result in dehydration, such as fever, gastroenteritis or diarrhoea are common in residential aged care. Medicines commonly used by people in residential aged care include diuretics, angiotensin-converting enzyme (ACE) inhibitors, angiotensin II receptor blockers (ARBs), non-steroidal anti-inflammatory agents (NSAIDs) and biguanides (for example, metformin). These medicines can cause adverse events in dehydrated individuals, particularly the elderly.

For instance:

- Diuretics such as furosemide can increase the risk of dehydration during episodes of gastroenteritis and can result in adverse events such as acute kidney injury, delirium or falls.[100] If symptoms persist beyond two days, renal function may need to be checked[101,102]
- In a dehydrated person, NSAIDs (such as ibuprofen, diclofenac and naproxen) may impair kidney function which could lead to kidney failure.[103]

Dehydration increases the risk of lactic acidosis, a serious and potentially life-threatening side effect of metformin, which is used to treat diabetes.[47] Other medicines that may require dose adjustment during periods of acute illness include insulin, renally cleared sulfonylureas and steroids used for long-term replacement therapy.

Comorbidities such as chronic kidney disease, diabetes and congestive cardiac failure are often present in elderly people and can contribute to adverse drug events during periods of acute illness.[47]

20. Use of dose administration aids (DAAs)

If unable to identify any medicines, registered 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.

Where DAAs are assessed to be appropriate for a person, information needs to be provided and discussed around the initiation and continuing use of DAAs, and their consent obtained. 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 person'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 14: Self-administration of medicines, for further advice).

21. Managing changes to medicines packed in DAAs

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.

Timely and accurate communication is required to at least:

- Facilitate 'immediate' or 'next-pack' changes
- Avoid delays or interruptions to continuity of medicines supply.

22. Medication reconciliation and DAAs

To minimise some of these types of errors or problems, and especially when changes are made to a person's DAA, their contents need to be reconciled against the person's medicines orders on their medication chart by the registered nurse (refer to Guiding Principle 10: Medication reconciliation). This needs to be completed in a timely manner, to ensure continuity of medicines supply. This should also be conducted at the time a residential medication management review (RMMR) is completed (refer to Guiding Principle 11: Medication review).

Reconciliation of medicines can involve pharmacist consultation with the person's prescriber to confirm the medicines list[53] is correct. Medication reconciliation should occur:

- Prior to packing the DAA for the first time
- After changes to medicines
- After return from hospital
- When temporary medicine administration changes are required – such as during episodes of acute illness.

23. Preparation of DAAs

DAAs are usually prepared by community pharmacists or by external providers. In some states and territories, in exceptional circumstances and where a pharmacist is not available, another health professional, such as a medical practitioner, registered nurse or Aboriginal Health Worker, may be authorised to prepare a DAA.

Timely and accurate communication is needed between prescribers (for instance, medical or nurse practitioners), pharmacists and RACF nurses about medicines ordered in DAAs, as the time between ordering, preparation and delivery can affect continuity of medicines supply (refer to Guiding Principle 12: Continuity of medicine supply including in an emergency).

24. Monitoring and reporting for DAA utilisation and quality

The use of DAAs in the RACF needs to be monitored and regularly reviewed for errors in labelling, packing and administration. DAAs also need to be monitored for any changes to the medicines – such as changes in colour or disintegration. If any deterioration is detected by the nurse, the medicine must not be administered, the incident reported as a medication incident and the DAA returned to the supplying pharmacy.

Monitoring also needs to include regular reconciliation of the DAA and the medication chart. Regular medication reconciliation should occur to ensure the person's list of medicines for packing in the DAA remains up to date and accurate.

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

For the individual, their carer and/or family

People (including those receiving 'respite care') are 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 and helped to understand information about:

- Medicines administration and self-administration policies, procedures and guidelines
- The assessment of a person's capacity and ability to self-administer their medicines, as well as appropriately store their medicines (refer to Guiding Principle 14: Self-administration of medicines)
- The assessment and consent process for use of and administration from DAAs
- The assessment for swallowing safety 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.

A person receiving care also has the right to choose an alternative treatment option. When a decision is being made to prescribe a medicine, a person has the right to choose the best option and will require information and understanding of the benefits and potential risks of choosing a medicine (refer to Guiding Principle 6: Selection of medicines).

People should be encouraged to hold 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[53], or Pharmacist Shared Medication List[66], held within the person's My Health Record. People should inform their visiting or primary healthcare provider (for instance, their general practitioner), pharmacists and registered nurses of all medicines they are taking, including medicines that they obtained without a prescription.

People thought to have swallowing difficulties will need to be screened for the risk of dysphagia before they are administered food, drink or oral dose forms of medicines. Individuals who are identified to have swallowing difficulties, making it unsafe for them to swallow oral dose forms, need to be referred to their primary healthcare provider or general practitioner and a pharmacist for review of their medicines. Involvement of a dietician, speech pathologist and/or an occupational therapist may also be recommended.

When a person is receiving short-term respite, they should receive the same care as that provided to others receiving care within the RACF. This includes supporting a person to self-administer their own medicines.

In addition, and depending upon the goals of care and level of independence at home, a person receiving short-term respite should expect to maintain their medicine-taking skills. However, if the person was able to manage their own medicines at home and their level of independences changes whilst in the RACF, this might necessitate being assessed to be capable of self-administering their medicines for when they return home.

Resources

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

Reflective questions

Administration

- How does the RACF ensure that medicines are administered safely and accurately and by nurses that are qualified, competent and authorised (according to the relevant state and territory legislation) to administer medicines?
- How does the RACF ensure that the administration of all medicines is documented?
- What processes are in place for the recording and reporting of medicine administration outcomes, including medication incidents and adverse drug events?

Dose administration aids

- How does the RACF address the supply, use, monitoring, storage and disposal of DAAs?
- What is the process for assessing an individual's suitability and capacity to use a DAA?

- ❖ What information is provided to an individual, their carer and/or family about DAA use, storage and disposal? How does the RACF ensure that this information meets their needs?
- ❖ How is the performance of the DAA system(s) monitored, reviewed and reported to the MAC?

Alteration of dosage forms

- ❖ What MAC endorsed policies, procedures and guidelines are in place on the alteration of dose forms of oral medicines?
- ❖ How does the RACF ensure that its healthcare workforce has 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 self-administering?

People with swallowing difficulties

- ❖ What is the process for assessing an individual's ability to safely swallow their medicines:
  - Upon admission
  - As a result of any change in the person's condition or ability to swallow?
- ❖ What information is provided to an individual, their carer and/or family about the need to assess their ability to swallow medicines and, if required, the referral process to their primary care practitioner, pharmacist or other health professional? How does the RACF ensure that this information meets their needs?

Management of an acute illness

- ❖ What information is provided to healthcare professionals and the individual receiving care, their carer and/or family about the management of an acute illness, including exacerbation of a chronic condition? How does the RACF ensure that this information meets healthcare professionals and the person receiving care's needs?

Information for respite care

- ❖ What information about the administration of medicines is provided to an individual (and their carer and/or family) who is being cared for temporarily as a result of admission for respite care?
- ❖ How does the RACF ensure that an individual receiving respite care maintains their medication-taking skills, especially if they have been self-administering their own medicines at home?

Resources

Guiding Principle	Relevant resources

 Guiding Principle 1	• Aged Care Quality and Safety Commission (ACQSC)
	  ○ Charter of Aged Care Rights[18]
	  ○ Aged Care Quality Standards[15]
	  ○ Guidance and resources for providers to support the Aged Care Quality Standards[104]
	  ○ Minimising use of restrictive practices[105]
	  ○ Consumer resource library[106]
	• Agency for Healthcare Research and Quality (AHRQ)[107] *The Patient Education Materials Assessment Tool (PEMAT) and User's Guide*[108]
	• Australian Commission on Safety and Quality in Health Care (ACSQHC)
	  ○ Australian Charter of Healthcare Rights[17]
	  ○ National Safety and Quality Health Service (NSQHS) Partnering with Consumers Standard[109]
	  ○ Person-centred care[110]
	  ○ Informed consent[72]
	  ○ Health literacy[111]
	  ○ Shared decision making[112]
	  ○ Tips for safe health care[113]
	  ○ Understanding your rights[114]
	  ○ *My Healthcare Rights – A guide for people with cognitive impairment*[115]
	  ○ Information for consumers[116]
	  ○ Identify goals of care[117]
	  ○ Working with your healthcare provider[118]
	  ○ Finding good health information[119]
	  ○ Translated information[120]
	  ○ National Standard for labelling dispensed medicine[121]
	  ○ Consumer representation guide for partnering with consumers[357]
	• Australian Government Department of Health and Aged Care
	  ○ Restrictive practices in aged care – a last resort[122]
	  ○ Restrictive practice use in aged care facilities – Overview[123]
	  ○ Types of restrictive practices[124]
	  ○ Informed consent for the use of restrictive practice[125]
	• Choosing Wisely Australia
	  ○ Consumers and carers[126]
	  ○ 5 questions to ask your doctor or other healthcare provider before treatment[127]
	• HealthWest Partnership and Inner North West Primary Care Partnership *Make it Easy: A handbook for becoming a health literate organisation*[128]
	• Older Persons Advocacy Network (OPAN)
	  ○ Charter of Aged Care Rights[18]
	  ○ *Medication: It's Your Choice*[126]
	  ○ OPAN Medication Booklet[129]
	• Sydney Health Literacy Lab[130] (SHeLL) Health Literacy Editor[131]

Guiding Principle	Relevant resources

	• Victorian Government Department of Health
	  ○ Improving access – fact sheets for clinicians[132]
	  ○ An interdisciplinary approach to caring[133]
	  ○ Improving communication[134]


Guiding Principle 2
	• Australian Commission on Safety and Quality in Health Care (ACSQHC)
	  ○ National Safety and Quality Health Service (NSQHS) Communicating for Safety Standard[135]
	  ○ Communicating for Safety resource portal[136]


Guiding Principle 3
	• Australian Government Department of Health and Aged Care *User Guide: Role of a Medication Advisory Committee*. This is a 'supplement' to the *Guiding Principles for Medication Management in Residential Aged Care Facilities*
	• Australian Commission on Safety and Quality in Health Care (ACSQHC)
	  ○ *Incident Management Guide*[35]
	  ○ State and territory incident management resources[137]
	  ○ Australian Open Disclosure Framework[138]
	  ○ Open Disclosure resources for health service organisations[139]
	  ○ *Open disclosure of things that don't go to plan in health care – A booklet for patients beginning an open disclosure process*[140]
	  ○ National Model Clinical Governance Framework[26]
	  ○ Australian hospital patient experience question set[141]
	  ○ Patient-reported outcome measures[142]
	• Consumer Health Forum (CHF) Guideline for consumer representatives[143]
	• Institute for Safe Medication Practices (ISMP) Canada Canadian Incident Analysis Framework[144]
	• Victorian Government Department of Health
	  ○ Aged care medication management resource kit[145]
	  ○ Resource Kit to enable implementation of the APAC Guidelines on Medication Management in Residential Aged Care Facilities (2006)[146]
	  ○ Evidence-based standardised care processes[147]

 Guiding Principle 4	• Australian Government Department of Health and Aged Care *User Guide: Role of a Medication Advisory Committee*. This is a 'supplement' to the *Guiding Principles for Medication Management in Residential Aged Care Facilities* • Australian Commission on Safety and Quality in Health Care (ACSQHC) Australian Atlas of Healthcare Variation Series[37] • Leading Aged Care Services Australia (LASA) YouTube video[148] – specifically addresses clinical governance • *National Aged Care Mandatory Quality Indicator Program Manual – 2.0 – Part A*[38]

Guiding Principle	Relevant resources

	• Royal Commission into Aged Care Quality and Safety *International and national quality and safety indicators for aged care* August 2020[39]
	• Victorian Government Department of Health resources for public sector residential aged care services
	  ○ Quality indicators in public sector residential aged care services[149]
	  ○ Section 3 – Indicator 4 – Use of nine or more medicines[150]


Guiding Principle 5
	Information resources relevant to medication management to be available in RACFs are listed below. They are broadly grouped into tools and information to support people receiving care and their carers; information resources about medicines, therapeutics, and services to support quality use of medicines (QUM); and legislation, regulation and standards for aged care, health professions and medicines.
	
	These resources may be additional to those also listed within each Guiding Principle.
	
	To support RACFs
	
	Aged care regulation and standards:
	
	• Australian Government *Aged Care Act 1997*[151] governs all aspects of the provision of residential care, flexible care and Community Aged Care for older Australians
	• Aged Care Quality and Safety Commission (ACQSC)[264] whose role is to protect and enhance the safety, health, wellbeing and quality of life of people receiving aged care
	  ○ Aged Care Quality Standards[15] are assessed and monitored by ACQSC. 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[152] (BPSD) infographic
	• Aged Care Quality and Safety Commission (ACQSC)
	  ○ Aged Care Quality Standard 8: Organisational governance[32] 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[105] outlines specific responsibilities of approved aged care providers
	  ○ Quality Care Principles 2014[153]
	  ○ National Aged Care Mandatory Quality Indicator Program (QI Program)[33] is a mandatory program for Australian Government-subsidised residential aged care providers. Data must be collected on quality indicators, which includes medication management with a focus on Poly-pharmacy and anti-psychotics
	• Australian Government Department of Health and Aged Care

Guiding Principle	Relevant resources

- Aged Care Clinical Advisory Committee[154] 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)[155]
- Six steps for safe prescribing of antipsychotics and benzodiazepines in residential aged care provides information and resources that support the appropriate management of dementia in a residential aged care setting
- Restrictive practices in aged care – a last resort[122] outlines specific information relating to restrictive practices including advice for providers of aged care and prescribers working in residential aged care

To support healthcare professionals

Health profession regulation, standards and guidelines:

- Australia and New Zealand Society for Geriatric Medicine (ANZSGM) Position statement 26: Management of Behavioural and Psychological Symptoms of Dementia (BPSD) (2016)[156]
- Australian Health Practitioner Regulation Agency (Ahpra)[157]
  - *Health Practitioner Regulation National Law Act 2009*[16]
- Australian Nursing and Midwifery Federation (ANMF) *Nursing Guidelines: Management of Medicines in Aged Care*[95]
- NSW Health and The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD) (2013)[158]
- Nursing and Midwifery Board of Australia (NMBA)
  - Registered nurse standards for practice[159]
  - Enrolled nurse standards for practice[160]
  - Decision-making framework for nursing and midwifery[161]
- Royal Australian College of General Practitioners (RACGP) *RACGP aged care clinical guide (Silver Book)*[48]
- Society of Hospital Pharmacists of Australia (SHPA)
  - Standards of Practice for Clinical Pharmacy Services[162]
  - Standard of practice in geriatric medicine for pharmacy services[163] 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 Pharmaceutical Society of Australia (PSA)
  - Medication Management Guidelines[164]
  - *Guidelines for Quality Use of Medicines (QUM) services*[40]
- Pharmacy Guild of Australia Quality Care Pharmacy Program (QCPP)[165]
- 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 dementia[166]

Guiding Principle	Relevant resources

	Medicine legislation and regulation:
	• Therapeutic Goods Administration (TGA) Standards for the Uniform Scheduling of Medicines and Poisons (SUSMP)[167] 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
	Legislation for drugs, poisons, and medicines administration for states and territories:
	• Australian Capital Territory (ACT)
	  ○ ACT Pharmaceutical Services[168]
	  ○ *Medicines, Poisons and Therapeutic Goods Act 2008*[169]
	  ○ Medicines, Poisons and Therapeutic Goods Regulation 2008[170]
	• New South Wales (NSW)
	  ○ NSW Health Pharmaceutical Services[171]
	  ○ *Poisons and Therapeutic Goods Act 1966 No. 31*[172]
	  ○ Poisons and Therapeutic Goods (Poisons List) Proclamation 2016[173]
	• Northern Territory (NT)
	  ○ NT Health Medicines and poisons[174]
	  ○ *Medicines, Poisons and Therapeutic Goods Act 2012*[175]
	  ○ Medicines Poisons and Therapeutic Goods Regulations 2014[176]
	• Queensland (Qld)
	  ○ *Medicines and Poisons Act 2019*[177]
	  ○ Medicines and Poisons (Medicines) Regulation 2021[55]
	  ○ Medicines and Poisons (Poisons and Prohibited Substances) Regulation 2021[178]
	  ○ Medicines and Poisons (Pest Management Activities) Regulation 2021[179]
	  ○ Therapeutic Goods Regulation 2021[180]
	• Queensland Health
	  ○ Medicines: Clinical guidelines and procedures[181]
	  ○ New medicines, poisons and pest management regulatory framework[182]
	  ○ Legislation, standards and extended practice authorities[183]
	  ○ Substance management plans (SMPs) for medicines[184]
	• South Australia (SA)
	  ○ Medicines and Technology Programs[185]
	  ○ Controlled substances legislation[186]
	  ○ *Controlled Substances Act 1984*[187]
	  ◦ Controlled Substances (Poisons) Regulations 2011[188]
	• Tasmania (Tas.)
	  ○ Medicines and poisons regulation[189] includes contact details for Tasmania Department of Health Pharmaceutical Services Branch
	  ○ *Poisons Act 1971*[190]
	  ○ Poisons Regulations 2018[191]
	• Victoria (Vic.)

Guiding Principle	Relevant resources
	○ Victorian Government Department of Health Medicines and Poisons[192] ○ *Drugs, Poisons and Controlled Substances Act 1981*[193] ○ Drugs, Poisons and Controlled Substances Regulations 2017[194] • Western Australia (WA) ○ WA Health Medicines and Poisons Regulation Branch[195] ○ *Medicines and Poisons Act 2014*[196] ○ Medicines and Poisons Regulations 2016[197] • Australian Government Department of Health and Aged Care Pharmacy Programs Administrator ○ Medication Management Programs[30] including services provided to RACFs by pharmacists to support medication management in aged care ○ Residential Medication Management Review (RMMR) and Quality Use of Medicines service[34] • Medicine references – a minimum standard set of materials could include ○ *Australian Immunisation Handbook*[198] ○ *Australian Injectable Medicines Handbook*[199] ○ *Australian Medicines Handbook* (AMH)[200] ○ AMH Aged Care Companion[201] ○ Australian *Therapeutic Guidelines*[202] ○ MIMS[203] and AusDI[204] – Australian product information and CMI ○ Micromedex[205] or Stockley's Drug Interactions[206] – references on medicine interactions ○ MedlinePlus[207] – references on complementary and alternative medicines ○ The Society of Hospital Pharmacists of Australia (SHPA) *Don't Rush to Crush*[97] ○ Australian Pharmaceutical Formulary[208] (APF) • Therapeutic Goods Administration (TGA) ○ Adverse events reporting[209] for healthcare professionals to report any suspected adverse events to a prescription, complementary or non-prescription medicine or medical device ○ Product information (PI)[210] provides a TGA-approved summary of the essential scientific information for the safe and effective use of a prescription medicine ○ Medicines safety updates[211] provides information and advice on medicine safety and emerging safety issues • Victorian Government Health Translations[212] is an online library which enables health practitioners and those working with culturally and linguistically diverse communities to easily find free translated health information **To support the individual, their carer and family** • Aged Care Quality and Safety Commission (ACQSC) ○ Charter of Aged Care Rights[18] protects the rights of people receiving Australian Government funded aged care services

Guiding Principle	Relevant resources
	○ Making a complaint[358] for people to raise their concerns about the care they or someone else is receiving in a constructive and safe way • Australian Commission on Safety and Quality in Health Care Australian Charter of Healthcare Rights[17] rights that apply to all people in all places where health care is provided in Australia • Australian Government My Aged Care[213] 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 Social Services *Carer Recognition Act 2010 Guidelines*[19] 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 Department of Veterans' Affairs (DVA) ○ Veterans' Medicines Advice and Therapeutic Education Services (Veterans' MATES)[214] helpful resources for veterans and healthcare professionals ○ Health and medicine topics[215] ○ Understanding your diuretic medicines[101] ○ Tips for remembering your medicines[216] ○ Therapeutic Brief – Staying health at home[217] includes a guide to deprescribing in Poly-pharmacy ○ Therapeutic Brief on preventing falls[218] information on medicines that may contribute to falls and hip fractures in older people • Victorian Government Department of Health Better Health Channel Medicines information leaflets for consumers[219] • Healthdirect[220] provides a wide range of reliable information on medicines, health topics and wellbeing, a question builder[221] for medical appointments, and how to read CMIs[222] • NPS MedicineWise ○ Adverse Medicine Event Line[223] or call 1300 134 237, for people to report and discuss adverse experiences with medicines ○ Consumer medicine information (CMI) explained[224] ○ Medicine Finder[225] ○ Medicines Line[226] or call 1300 MEDICINE (1300 633 424), providing information on prescription, complementary and non-prescription (over-the-counter) medicines ○ Medicines list[227] to assist people to keep an up-to-date record of all medicines taken and is available in several languages • Medicines.org.au. CMI search[228] • Pharmacy Guild of Australia (PGA) Consumer medicines information[229] – CMI Support materials for pharmacists • Therapeutic Goods Administration (TGA) ○ Consumer medicines information[230] an index of CMI searchable by medicine, trade name or active ingredient ○ Reporting a problem of side effect about medicines or medical devices[231]

Guiding Principle	Relevant resources

 Guiding Principle 6	• Australian Commission on Safety and Quality in Health Care (ACSQHC)
	  ○ Antimicrobial stewardship Book – Chapter 16. Antimicrobial stewardship in aged care[84]
	  ○ Fact sheet – Topical antifungals aged care[232]
	  ○ Fact sheet – Asymptomatic bacteriuria[233]
	• Australian Government Department of Health Six steps for safe prescribing of antipsychotics and benzodiazepines in residential aged care[234]
	• Choosing Wisely Australia[235]
	• End of Life Directions for Aged Care (ELDAC) ELDAC Toolkits[236]
	• Victorian Government Department of Health. Australian Centre for Evidence Based Care (ACEBAC) LaTrobe University Standardised Care Process (SCP) for polypharmacy[237]
	• National Disability Insurance Scheme (NDIS) Practice alerts[238]
	  ○ Dysphagia, safe swallowing and mealtime management[96]
	  ○ Epilepsy management[239]
	  ○ Medicines associated with swallowing problems[98]
	  ○ Polypharmacy[240]
	• NSW Agency for Clinical Innovation (ACI) Frailty Taskforce[241]
	• NSW Health End of life and palliative care medication prescribing[242]
	• NSW Clinical Excellence Commission (CEC)
	  ○ Last Days of Life Toolkit[243]
	  ○ Older Person's Patient Safety Program[244]
	• NPS MedicineWise
	  ○ *Prescribing Competencies Framework: embedding quality use of medicines into practice (2nd Edition)* [245] for all health professionals permitted to prescribe (2nd edition) 2021
	  ○ Anticholinergic burden: the unintended consequences for older people[246]
	• Royal Australian College of General Practitioners (RACGP)
	  ○ *RACGP aged care clinical guide (Silver Book)*[48]
	  ○ Prescribing considerations for people with dementia[247]
	• The Australian Pain Society (APSOC)
	  ○ Pain in Residential Aged Care Facilities: Management Strategies[248]
	  ○ The PMG Kit: An implementation kit to accompany Pain in Residential Aged Care Facilities: Management Strategies[249]
	• Therapeutic Goods Administration (TGA) Medicines safety updates[211]
	• Australian *Therapeutic Guidelines* Antibiotic Prescribing in Primary Care Summary Table[250]
	• University of Sydney Goal-directed Medication review Electronic Decision Support System (G-MEDSS) – includes a Drug Burden Index (DBI) Calculator tool[251]
	Tools for minimising inappropriate polypharmacy

Guiding Principle	Relevant resources

	• Australian Commission on Safety and Quality in Health Care (ACSQHC) infographic – Reducing inappropriate use of antipsychotics in people with behavioural and psychological symptoms of dementia (BPSD)[52]
	• NSW Therapeutic Advisory Group (TAG) Deprescribing tools[252]
	• Primary Health Network (PHN) Tasmania
	  ○ Managing Medicines programme[253]
	  ○ Deprescribing resources[254]
	'Sick day' management
	• Australian Diabetes Educator Association (ADEA) Clinical Guiding Principles for Sick Day Management of Adults with Type 1 Diabetes or Type 2 Diabetes A Guide for Health Professionals[255]
	• Healthcare Improvement Scotland Primary care resources[256]
	• Think Kidneys UK Position statement on 'sick day rules'[257]
	• Understanding the implementation of 'sick day' guidance[258]
	Education and training
	• Dementia Training Australia Too much of a good thing: fundamentals of deprescribing[259]
	• NSW Government Health Education and Training Institute. Polypharmacy in older inpatients[260] – eLearning module
	• NPS MedicineWise and ACSQHC Antimicrobial prescribing modules Antimicrobial prescribing modules[261] (in particular catheter-associated urinary tract infection)
	Information for consumers
	• NSW Therapeutic Advisory Group (TAG) Deprescribing tools[252] – consumer information leaflets
	• Tasmania Primary Health Network (PHN) Rethinking your medicines consumer brochure[262]
	Referral tools
	• Queensland Health Medication review or poly-pharmacy[263] – Minimum referral criteria for GPs
	Other resources
	• Aged Care Quality and Safety Commission (ACQSC)[264]
	• National Centre for Antimicrobial Stewardship (NCAS)
	  ○ National Antimicrobial Prescribing Survey (NAPS)[265] – to participate in Aged Care NAPS
	  ○ NCAS Aged Care Resources[266]

GUIDING PRINCIPLE 7	• Australian Medical Association (AMA) AMA position statement – complementary medicine – 2018[267] • Choosing Wisely Australia Choose your complementary medicines wisely[268] • Council for Australian Therapeutic Advisory Groups (CATAG) Position statement for the use of complementary and alternative medicines, May 2015[269] • Medline Plus. US National Library of Medicine Drugs, herbs and supplements[270]

Guiding Principle	Relevant resources

Guiding Principle 7	• National Health and Medical Research Council (NHMRC) Talking with your patients about Complementary Medicine – a Resource for Clinicians[271]
	• NPS MedicineWise Complementary medicines explained[272]
	• Pharmaceutical Society of Australia (PSA)
	  ○ Australian Pharmaceutical Formulary (APF) APF25 Complementary Medicines Monographs Reference List[273]
	  ○ PSA Position statement – Complementary medicines[274]
	  ○ Find education that's right for you[275] – education and training on complementary medicines for pharmacists
	• Royal Australian College of General Practitioners (RAGCP) *RACGP aged care clinical guide (Silver Book)* 5th edition Part B. Principles of medication management[67]
	• Therapeutic Goods Administration (TGA)
	  ○ Complementary medicines[276]
	  ○ Over-the-counter medicines[277] (non-prescription medicines)
	  ○ Product information (PI)[210] and consumer medicines information (CMI)[230]
	• Victorian Government Department of Health Better Health Channel Complementary medicines[278]


Guiding Principle 8
	• The Australian Nursing and Midwifery Federation (ANMF) *Nursing Guideline: Management of Medicines in Aged Care*[95]
	• NSW Health
	  ○ NSW Clinical Excellence Commission (CEC) Last Days of Life toolkit[243]
	  ○ End of life and palliative care medication prescribing[242]
	National, state and territory medicines and poisons contacts for legislation (however named)
	• Therapeutic Goods Administration (TGA) Poisons Standard: Standard for the Uniform Scheduling of Medicines and Poisons[167]
	• ACT Pharmaceutical Services[168]
	• NSW Health Pharmaceutical Services[171]
	• Northern Territory (NT) Health Medicines and poisons[174]
	• Queensland Health
	  ○ Medicines[181]
	  ○ New medicines, poisons and pest management regulatory framework[182]
	  ○ Legislation, standards and extended practice authorities[183]
	  ○ Substance management plans (SMPs) for medicines[184]
	• SA Health
	  ○ Medicines and Technology Programs[185]
	  ○ Controlled substances legislation[186]
	  ○ Medicines and poisons regulation[189] includes contact details for the Tasmania Department of Health Pharmaceutical Services Branch
	• Victorian Government Department of Health Medicines and Poisons[192]
	• WA Health Medicines and Poisons Regulation Branch[195]

Guiding Principle	Relevant resources


Guiding Principle 9
	• Australian Commission on Safety and Quality in Health Care (ACSQHC)
	  ○ National Residential Medication Chart (NRMC)[63]
	  ○ Electronic National Residential Medication Chart (eNRMC)[57] resource documents for RACFs and software vendors
	  ○ *National guidelines for on-screen display of medicines information*[280]
	  ○ Recommendations for terminology, abbreviations and symbols used in medicines documentation[281]
	  ○ Interim Residential Care Medication Administration Charts. The MedGap Project[282]
	• Government of South Australia (SA) Fact sheet: Interim Medication Chart (IMAC)[283]


Guiding Principle 10
	• Agency for Healthcare Research and Quality (AHRQ) Medication at transitions and clinical handoffs (MATCH) toolkit for medication reconciliation 2012[284]
	• Australian Commission on Safety and Quality in Health Care (ACSQHC)
	  ○ Aged Care Home Transfer to Hospital envelope[285]
	  ○ *High 5s Project Assuring Medication Accuracy at Transitions of Care – Australian Interim Report January 2010–March 2013*[286]
	  ○ Medication reconciliation resources[287]
	  ○ Medication reconciliation standard operating procedures (SOPs)[288]
	  ○ Obtaining a best possible medication history[289] (BPMH)
	• Institute for safe medication practices (ISMP) Canada
	  ○ Medication reconciliation (MedRec)[290]
	  ○ 5 questions to ask about your medications[291]
	• NPS MedicineWise
	  ○ Keeping a medicines list[53]
	  ○ Managing your medicines[292]
	  ○ Online learning module: Get it right! Taking a best possible medication history (BPMH)[293]
	  ○ The importance of medication reconciliation for patients and practitioners (2012)[294]
	• NSW Clinical Excellence Commission (CEC) Best possible medication history interview guide[71]
	• Pharmaceutical Society of Australia (PSA)
	  ○ *Guidelines for pharmacists providing dose administration aid services*[295]
	  ○ *Guidelines for comprehensive medication management reviews*[68]
	• Online learning module: Developing a Medication Management Plan[296]
	• Pharmacy Guild of Australia (PGA)
	  ○ Quality Care 2020 Framework[70]
	  ○ Quality Care Community Pharmacy Program and Standard[28] – AS85000:2017
	• Victorian Government Department of Health Medication reconciliation[297]

Guiding Principle	Relevant resources


Guiding Principle 11
	• Australian Commission on Safety and Quality in Health Care (ACSQHC) National Safety and Quality Health Service (NSQHS) Medication Safety Standard[298]
	• Australian Government Department of Health and Aged Care
	  ○ Medicare Benefits Online[299]
	  ○ Pharmacy Programs Administrator Residential Medication Management Review and Quality Use of Medicines Services[34]
	  ○ Residential Medication Management Review Patient Consent Form[300]
	  ○ National Disability Insurance Scheme (NDIS) Practice alerts[238]
	  ○ Dysphagia, safe swallowing and mealtime management[96]
	  ○ Epilepsy management[239]
	  ○ Medicines associated with swallowing problems[98]
	  ○ Polypharmacy[240]
	• NPS MedicineWise Anticholinergic burden: the unintended consequences for older people[246]
	• Pharmaceutical Society of Australia (PSA)
	  ○ *Guidelines for comprehensive medication management reviews* (2020)[68]
	  ○ Professional Practice Standards (Version 5)[301]
	• Pharmacy Guild of Australia Quality Care Pharmacy Program (QCPP) Domain 4: Additional requirements for medicines management services
	• Royal Australian College of General Practitioners (RACGP) *RACGP aged care clinical guide (Silver Book)*[48]
	  ○ Part A: Deprescribing[43]
	  ○ Part A: Medication management[302]
	  ○ Part A: Polypharmacy[49]
	  ○ Part B: Collaboration and multidisciplinary team-based care[303]
	  ○ Part B: Medicare Benefits Schedule item numbers[73]
	• The Society of Hospital Pharmacists of Australia (SHPA)
	  ○ Standards of practice in geriatric for pharmacy services[163]
	  ○ Fact sheet: Risk Factors for Medication-related problems[304]

 Guiding Principle 12	• Australian Government Department of Health and Aged Care *Guiding Principles to Achieve Continuity in Medication Management* • Government of South Australia (SA) Interim Medication Administration Chart (IMAC)[305] for SA Health hospitals and health services • Queensland Health Implementation tool-kit for Residential Aged Care Support Services (RaSS)[306] includes information about an Interim Medication Administration Record (IMAR) which provides a discharge medication list for patients discharged to residential aged care facilities in Queensland **Management of emergency medicines in RACFs** • Pharmaceutical Society of Australia (PSA) *Guidelines for Quality Use of Medicines (QUM) services*[40]

Guiding Principle	Relevant resources

	Requirements for imprest stocks that are state and territory specific
	• Imprest Medication Systems for RACFs[307] developed by the Southern Metro Region Palliative Care Consortium in Victoria and updated by Gippsland Region Palliative Care Consortium (April 2020)
	• Victorian Government Resources relating to medicines storage and record keeping in RACFs[308]
	• NSW Health
	  ○ Resources on Urgent Use medications in RACFs[79]
	  ○ Information Bulletin 2003/10: Guide to the Handling of Medication in Nursing Homes in NSW[309]

 Guiding Principle 13	• Australian Government Department of Health and Aged Care National Vaccine Storage Guidelines – Strive for 5[87] • Pharmaceutical Society of Australia (PSA) *Guidelines for pharmacists providing dose administration aid services*[295] • Pharmacy Guild of Australia Quality Care Pharmacy Program (QCPP)[70] Domain 5: Additional requirements for DAAs • Return Unwanted Medicines (RUM) Project[86] or call 1300 650 835 • Therapeutic Goods Administration (TGA) Product information[210] (PI) which provides details of each medicine's storage requirements
 Guiding Principle 14 and Guiding Principle 15	**Administration of medicines** • Australian Nursing and Midwifery Federation (ANMF) *Nursing Guidelines: Management of Medicines in Aged Care* (2013)[95] • WA Health Six rights of safe medication administration[310] • Institute for Healthcare Improvement Five rights of medication administration[311] • Wolters Kluwer Nursing Centre Blog – 8 rights of medication administration[312] • Nursing Notes UK 10 rights of medication administration[313] **Advocacy information** • Aged Care Quality and Safety Commission (ACQSC) Charter of Aged Care Rights[18] • Choosing Wisely Australia Consumers and carers[126] • Older Persons Advocacy Network (OPAN) *Medication: It's Your Choice*[129] **Alteration of oral dose forms** • *Australian Medicines Handbook* (AMH) AMH Aged Care Companion Drug Choice Companion[201] • Pharmaceutical Society of Australia (PSA) *Australian Pharmaceutical Formulary and Handbook*[208] • The Society of Hospital Pharmacists of Australia (SHPA) *Don't Rush to Crush*[97] **Assessment resources**

Guiding Principle	Relevant resources

- Speech Pathology Australia Dysphagia Clinical Guideline (2012)[314]
- International Dysphagia Diet Standardisation Initiative (IDDSI) IDDSI Framework[315] – describing food textures and drink thicknesses

Consumer medicines information (CMI)

- Healthdirect How to read CMIs[222]
- Medicines.org.au CMI search[228]
- NPS MedicineWise
- Medicine Finder[225]
- Consumer medicine information (CMI) explained[224]
- Pharmacy Guild of Australia (PGA) Consumer medicines information[229] – CMI Support materials for pharmacists
- Pharmaceutical Society of Australia (PSA) PSA Dispensing practice standards (2019)[316]
- Therapeutic Goods Administration Consumer medicines information[230] – an index of CMI searchable by medicine, trade name or active ingredient
- Victorian Government Department of Health Better Health Channel
  - Medicines information leaflets for consumers[219]
  - Pill Reminder and Medication Reminder[317]

Documentation

- Australian Commission on Safety and Quality in Health Care (ACSQHC)
  - Electronic national residential medication chart (eNRMC)[57]
  - National Residential Medication Chart (NRMC)[63]
  - *User guide for nursing and care staff*[318]
  - *User guide for pharmacists*[319]
  - *User guide for prescribers*[320]

Dose administration aids (DAAs)

- NPS MedicineWise *Australian Prescriber* Appropriate use of dose administration aids[321]
- Pharmaceutical Society of Australia (PSA)
  - *Guidelines for pharmacists providing dose administration aid services* – Appendix 6 (2017)[69]
  - Professional practice standards. Version 5 Standard 15 (2017)[301]
- Pharmacy Board of Australia (PBA) Guidelines on dose administration aids and staged supply of dispensed medicines 2015[94]
- Pharmacy Guild of Australia Quality Care Pharmacy Program (QCPP)[70] – Domain 5: Additional requirements for DAAs

Examples of medicines lists

- NPS MedicineWise
  - Medicines lists in community languages[227] – to print off in English and 10 other languages

Guiding Principle	Relevant resources
	○ MedicineWise app[322] for smartphones **Fact sheets and other resources on managing medicines** • Australian Government Department of Health and Aged Care ○ Information for consumers[323] ○ Health topics – Medicines[1] • Australian Government Department of Veterans' Affairs (DVA) Veterans' Medicines Advice and Therapeutic Education Services[214] (Veterans' MATES) – helpful resources for veterans and healthcare professionals ○ Health and medicine topics[215] ○ Therapeutic Brief – Staying healthy at home[217] – includes a guide to deprescribing in polypharmacy ○ Therapeutic Brief on preventing falls[218] – information on medicines that may contribute to falls and hip fractures in older people ○ Tips for remembering your medicines[216] ○ Understanding your diuretic medicines[101] • National Disability Insurance Scheme (NDIS) Practice alerts[238] ○ Dysphagia, safe swallowing and mealtime management[96] ○ Epilepsy management[239] ○ Medicines associated with swallowing problems[98] ○ Polypharmacy[240] • National Health and Medical Research Council (NHMRC) *Talking to patients about complementary medicine – a resource for clinicians*[271] • NPS MedicineWise ○ Keeping a medicines list[53] ○ Managing your medicines[292] **Managing acute illness** • National Health Scheme (NHS) Scotland ○ Medicine Sick Day Rules card and resources[256] ○ Medicines and Dehydration[324] – patient information leaflet ○ Medicines and Dehydration[103] – briefing for professionals on the Medicine Sick Day Rules card ○ Medicine Sick Day Rules card[325] for patients outlining which medicines they should stop on 'sick days' and advice on when/how to restart the medicines once they are better ○ Self-administration assessment • Kinny Legal Pty Ltd Dignity of risk under the Aged Care Quality Standards[326] • Victorian Government Department of Health Example of self-administration of medication assessment[327] **Standards** • Aged Care Standards Standard 1: Consumer dignity and choice[22]

Appendix: Background information

This Appendix contains background information relating to the Guiding Principles. It includes details of:

- Emerging areas of importance in medication management
- Aged Care Quality Standards
- Communication and health literacy
- Person-centred care
- QUM and medicines safety
- Royal Commission into Aged Care Quality and Safety
- Support and initiatives
- Transitions of care
- Workforce
  - nurse prescribers
  - pharmacists
  - general practitioners
  - rural practice.

Emerging areas of importance in medication management

Research has shown that emerging areas of importance within the residential aged care setting include:

- Greater use of digital solutions for medication management
- New models of care – such as embedded pharmacists in RACFs
- The importance of deprescribing
- Polypharmacy and high-risk medicines – for instance, inappropriate psychotropic use in aged care
- Transitions of care and continuity issues – for instance
  - entry to aged care from the community
  - transition from hospital back to aged care
  - transition of care between general practitioners (GPs) and specialists
- Non-medical initiation of medicines (prescription and non-prescription)
- Mandatory National Aged Care Quality Indicators[33] to monitor the quality of care provided to aged care recipients, including two medicines-related indicators
- Serious Incident Reporting Scheme (SIRS).[36]

Aged Care Quality Standards

The Aged Care Quality and Safety Commission (ACQSC) was established on 1 January 2019. The ACQSC works under the *Aged Care Quality and Safety Commission Act 2018* and the Aged Care Quality and Safety Commission Rules 2018. The ACQSC is a non-corporate Commonwealth entity under the *Public Governance, Performance and Accountability Act 2013*.

From January 2020, the ACQSC incorporated the aged care regulatory functions of the Australian Government Department of Health.

The ACQSC's purpose is 'to protect and improve the safety, health, wellbeing and quality of life of people receiving Australian funded aged care'. It is also responsible for:

- Granting approval for providers[328] to deliver aged care services
- Administering the Serious Incidents Response Scheme[36]
- Reducing the use of restrictive practices.[105]

Since July 2019, providers of aged care services in Australia have been expected to transition and comply with a new set of Aged Care Quality Standards[15] and have continuous improvement plans in place.

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.[329] Given the roles of medicines in disease management a definition of medication literacy[330] was published in 2022 by the Pharmaceutical Federation Internationale (FIP) Foundation for Education and Research. The definition includes a series of statements as to the type of information for 'optimal and safe use of' medicines.

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.[2]

It calls for, for example, greater emphasis on cultural safety in providing medication management services to Aboriginal and Torres Strait Islander peoples.

The Australian Institute of Health and Welfare reported in 2016 that 37% of people aged 65 and over were born overseas, and that the majority of these were born in a non-English speaking country.[331] About 6% reported speaking another language, and speaking English only poorly, or not at all. These older Australians may face substantial language barriers in accessing healthcare services. Those with differing cultural practices and norms can lead to a lack of understanding of, and barriers to, service use. In February 2019, *Actions to support older Culturally and Linguistically Diverse people – A guide for aged care providers*[332] was published. It aims for all older people to experience a high-quality aged care system that ensures equitable access and outcomes embracing their diverse characteristics and life experiences.[333]

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 Third World Health Organization (WHO) Global Patient Safety Challenge: Medication Without Harm[334] aims to halve preventable medication related harm by 2023. Australia's response[42] 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[335] and findings within the Final Report of the Royal Commission into Aged Care Quality and Safety.[8]

Poly-pharmacy, high risk medicines and transitions of care have also been identified as priority areas within Australia's response[42] to the Third WHO Global Patient Safety Challenge: Medication Without Harm.

Governance of medication management requires the establishment and empowerment of a multidisciplinary medicines governance group (however titled). Within a RACF a medication advisory committee (MAC) usually fulfils this role by supporting safe and effective medication

management and QUM within the facility. However, a 2020 Victorian study concluded that opportunities exist to improve composition and structure, proactive identification and response to emerging issues, and systems for education and training of the workforce, the individual receiving care and their carer and/or family.[336] This research and recommendations relating to governance from the Royal Commission into Aged Care Quality and Safety highlight the opportunity to strengthen the governance of medication management and QUM within RACFs.[8]

Royal Commission into Aged Care Quality and Safety

In February 2021, the Commissioners delivered their Final Report: Care Dignity and Respect[8] making a call for fundamental reform of the aged care system. In May 2021, the Australian Government published its response.[337] The Final Report[8] emphasised key areas of importance such as the:

- Universal adoption of digital technology by the aged care sector, with the use of My Health Record to support improved medication management practices in the aged care sector
- Need for better aged care clinical governance and the need for monitoring of performance, workforce leadership, development, skills and culture.

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 (MHR)[338] to assist secure, electronic sharing of information on a person's health care, including medicines information, is yet to be realised by the residential aged care sector. However, the Australian Government Department of Health launched new programs in 2022 to promote the adoption of MHR by aged care facilities, as well as the integration of aged care clinical systems with MHR. The programs are expected to significantly increase MHR adoption and use and improve interoperability with aged care systems.

Other national initiatives include:

- The Medication safety program of the Australian Commission on Safety and Quality in Health Care (the Commission) – including the National Residential Medication Chart (NRMC)[63] and electronic NRMC[57]
- The Commission's Australian Atlas of Healthcare Variation Series[37], and Antimicrobial Stewardship in Aged Care[51] resources
- Prescriber and community information and education programs through NPS MedicineWise[339]
- The national recognition of health professionals through the Australian Health Practitioner Regulation Agency (Ahpra)[157]
- Pharmaceutical Society of Australia *Guidelines for Clinical Governance in pharmacy services*[27]
- Pharmacy Guild of Australia Quality Care 2020 Framework[70] and Quality Care Community Pharmacy Program and Standard[28] – AS85000:2017
- The electronic National Residential Medication Chart (eNRMC) adoption grant opportunity by the Department of Health; this grant will incentivise all aged care facilities to adopt an eNRMC; these charting systems have been shown to improve medications safety and quality of care
- A new initiative to digitalise aged care transfer summaries (ACTS) launched by the Department of Health will deliver a digital ACTS which can draw medicines-related information directly from electronic National Residential Medication Charts: creating a single, current source of medicines information for people in residential aged care;

aged care facilities will be able to send and receive medicines-related information – for instance, when care is transferred to/from other facilities such as hospitals.

Transitions of care

Movement of people across care settings challenges continuity of medication management, particularly for people with complex and chronic needs. This increases the potential for mistakes, oversights, and misunderstandings. Commonly reported problems during transitions include poor transfer of information. For instance, it is reported that:

- Up to 90% of people may experience a change to their medicines whilst in hospital
- Up to 42% of people may be prescribed at least one potentially inappropriate medicine at discharge from hospital
- Only 12% of people had a hospital 'separation summary' that addressed the issues related to potentially inappropriate medicines as defined by Beers Criteria.[3]

Inadequate arrangements for continuing medicines supply and the absence of an up-to-date medication chart can also lead to medication errors. These include, for example:

- Missed or significantly delayed doses
- Problems accessing medicines-related information
- Supply of suitably packed medicines on short notice.[340]

In addition, even if adequate supplies of medicines are supplied at discharge, they can be wasted if they are not packaged in the preferred manner, such as in a unit-dose or multi-dose administration aid.[341] Interventions involving a multidisciplinary team, pharmacist-led medication reconciliation and the provision of accurate discharge information have been identified as improving continuity of medication management during transitions of care from hospital to a RACF.[342] This includes use of a paper-based interim residential care medication administration charts (IRCMACs) which have been implemented in Victoria, Queensland and South Australia. Hospital pharmacy prepared IRCMACs, accompanied by supplies of medicines, have been shown to be effective to assist continuity of medication management when a person transfers from hospital to a RACF.[343] The primary purpose of the IRCMAC is to enable the RACF healthcare team to safely administer medicines to a person transferred from hospital whilst awaiting a new or updated RACF medication chart (paper-based or electronic).[343]

Workforce

In 2016, the latest year for which comprehensive data are publicly available, there were 154,000 direct care workers in the residential aged care sector (an increase of 3% since 2012 on a full-time equivalent basis).[10]

The aged care workforce comprises doctors, nurses, pharmacists, care workers (however titled), optometrists, physiotherapists, podiatrists and other allied health professionals. The interactions between various members of the residential aged care workforce are critical to the quality and safe use of medicines for people living in RACFs.

Medicines-related tasks are increasingly delegated to unregistered and unqualified workers. There are decreasing numbers of registered nursing staff in the sector and a corresponding increase in the number of unregistered assistants in nursing and personal care workers (PCWs) (however titled). Workforce education and training is required to adequately equip the aged care workforce with the knowledge and skills to provide quality care.

In 2018, Australia's Aged Care Workforce Strategy: A Matter of Care[344] was released. Strategy 3 seeks to reframe the qualifications and skills to address gaps and boost competencies – in particular, for PWCs.

Nurse prescribers

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.[345] The Health Professionals Prescribing Pathway (HPPP)[346] published by Health Workforce Australia (HWA) in November 2013 was developed as a nationally recognised approach to the prescribing of medicines by healthcare professionals (other than medical practitioners) registered under the National Registration and Accreditation Scheme.

Nurse practitioners (NPs) have an increasing role in aged care. In aged care settings, nurse practitioners can provide support and direction to registered nurses and enrolled nurses in managing the complex care needs of people with chronic disease – such as diabetes, respiratory conditions, urinary conditions, and cardiac disease – and in providing timely intervention to prevent unnecessary admission to hospital.

Pharmacists

Pharmacy services to and within RACFs continue to develop. For over 20 years, the Australian Government has funded medication reviews by pharmacists. The current program rules[34], ratified in the 7th Community Pharmacy Agreement (7CPA)[347], fund collaborative Residential Medication Management Reviews or RMMRs (in-person or by telehealth). The 7CPA also supports additional services and activities by pharmacists, aimed at supporting QUM, including the safe use of medicines, within Australian Government-funded aged care facilities. Such QUM services can include staff education and training, continuous quality improvement (CQI) activities, participation in the RACF's medicines governance group – for example, the medication advisory committee – and involvement in the development of policies, procedures and guidelines, especially in relation to medication management concerns.

There is a requirement for Quality Care Pharmacy Program (QCPP)[70] accreditation for pharmacies to be eligible for CPA program funding. However, this can also be a prerequisite for a range of other services provided by community pharmacy, including vaccinations, the National Diabetes Supply Scheme (NDSS) and some state based (and funded) pharmacy services – for instance, those being implemented in South Australia.

Whilst the limited research evidence indicates that on-site or embedded pharmacists improve medication management and health outcomes for people in residential aged care[348], from 2023, the Australian Government is making funding available for RACFs to employ pharmacists. In its *Final Report: Care Dignity and Respect*[8] the Aged Care Royal Commission recommended improved access to medication reviews by funding pharmacists to conduct reviews on peoples' entry to residential aged care. Australian and ACT Government supported trials of embedded pharmacists in aged care have been conducted in Australia[349], and pioneered by ACT's Goodwin Aged Care in late 2018 after a successful trial. A collaboration of universities[350] in four states also launched pilots or trials.

General practitioners

Obtaining timely access to GPs continues to be a problem, for both individual care needs and facility wide roles in medication management, governance and quality improvement. Provision of timely and high-quality GP services in Australian RACFs is essential for the sector's expanding population, who have the substantial and complex healthcare needs described above. There is evidence that past methods of delivering GP services to this population were not optimal, and there have been high and rising rates of acute care services use[351] along with concerns about the quality of services provided.[352] Various models of GP service delivery have been described[353] and whilst an interdisciplinary team-based model may be ideal, this approach may not always be possible.

Effective from 1 July 2021, the General Practitioner Aged Care[354] practice incentive program (PIP) has been in place to encourage GPs to provide increased and continuing services in

Australian Government funded RACFs. It includes an incentive payment to support quality improvement in health outcomes and delivery of care. However, RACF Boards of Management and Executives may need to consider practical ways in which to attract and retain active involvement of GPs on a RACF medicines governance group.

Rural practice

RACFs in rural and remote areas face additional barriers in access to GPs, NPs and pharmacists. Rural GPs' workload and time constraints make it difficult to spend time away from in-practice work to service aged care facilities.[355] 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.[356]

Acronyms and abbreviations

Acronyms and abbreviations	Description
7CPA	7th Community Pharmacy Agreement
ACQSC	Aged Care Quality and Safety Commission
ACSQHC	Australian Commission on Safety and Quality in Health Care
ACT	Australian Capital Territory
ACTS	Aged Care Transfer Summary
Ahpra	Australian Health Practitioner Regulation Authority
AHRQ	Agency for Health Research and Quality
AIR	Australian Immunisation Register
AMA	Australian Medical Association
AMH	*Australian Medicines Handbook*
ANMF	Australian Nursing and Midwifery Federation
APF	Australian Pharmaceutical Formulary
BPMH	best possible medication history
BPSD	behavioural and psychological symptoms of dementia
CAL	cautionary advisory label
CALD	culturally and linguistically diverse
CATAG	Council of Australian Therapeutic Advisory Groups
CEC	Clinical Excellence Commission
CMI	consumer medicines information
COPD	congestive obstructive pulmonary disease
CQI	continuous quality improvement
DAA	dose administration aid
DBI	drug burden index
DUE	drug utilisation evaluation

Acronyms and abbreviations	Description
DVA	Department of Veterans' Affairs
eMM	electronic medication management
EN	enrolled nurse
eNRMC	electronic National Residential Medication Chart
GP	general practitioner
HMR	Home Medicines Review
IDDSI	International Dysphagia Diet Standardisation Initiative
IRCMAC	interim residential care medication administration chart
LASA	Leading Aged Care Services Australia
MAC	Medication Advisory Committee
MMP	medication management plan
My HR	My Health Record
NAPS	National Antimicrobial Prescribing Survey
NCAS	National Centre for Antimicrobial Stewardship
NDIS	National Disability Insurance Scheme
NDSS	National Diabetes Supply Scheme
NHMRC	National Health and Medical Research Council
NHS	National Health Scheme
NIM	Nurse-initiated medicine
NMBA	Nursing and Midwifery Board of Australia
NMP	National Medicines Policy
NP	nurse practitioner
NRMC	National Residential Medication Chart
NSAID	Non-Steroidal Anti-inflammatory Drug
NSQHS	National Safety and Quality Health Services

Acronyms and abbreviations	Description
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
PCW	personal care worker
PGA	Pharmacy Guild of Australia
PHN	Primary Health Network
PI	product information
PREMs	patient-reported experience measures
PRN	*pro re nata* (when required or if necessary)
PSA	Pharmaceutical Society of Australia
QCPP	Quality Care Pharmacy Program
QUM	quality use of medicines
RACF	residential aged care facility
RACGP	Royal Australian College of General Practice
RANZCP	The Royal Australian and New Zealand College of Psychiatrists
RMMR	Residential Medication Management Review
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

Acronyms and abbreviations	Description
TGA	Therapeutic Goods Administration
UK	United Kingdom
WHO	World Health Organization

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