Australian Nursing and Midwifery Federation submission to the

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE ON THE QUALITY USE OF MEDICINES AND MEDICINES SAFETY (10TH NATIONAL HEALTH PRIORITY) PUBLIC CONSULTATION - PHASE 1: AGED CARE

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INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 295,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

With regard to care of older people, ANMF members work across all settings in which aged care is delivered, including over 40,000 members who are currently employed directly in the aged care sector. Many more of our members are involved in the provision of health care for older persons who move across sectors (acute, residential, community and in-home care), depending on their health needs. Being at the forefront of aged care, and caring for older people over the twenty-four hour period in acute care, residential facilities and the community, our members are in a prime position to make clear recommendations to improve the care provided and enhance processes for access to that care.

The ANMF welcomes the opportunity to provide a response to the Australian Commission on Safety and Quality in Healthcare's public consultation on Quality Use of Medicines (QUM) and Medicine Safety - Phase 1: Aged care. We support the establishment of QUM and medicines safety as a national health priority area. With the focus on the areas of polypharmacy, use of antipsychotic medicines, and transitions of care between care settings, the discussion paper has provided a thorough, detailed and comprehensive review of current research addressing the issues relating to medicines related harm in aged care.

The goal of any medicines service for older people should be to promote quality of life and support end of life care. While medicines make a significant contribution to the treatment of ill health, the prevention of disease, increasing life expectancy, and improving health outcomes, they also have the potential to cause harm.[1] As noted in the discussion paper's introduction, in addition to prescribing issues (i.e. errors related to dosing, medicines selection, indications for use, and interactions), there is potential for error and need for monitoring in the use of medicines, from dispensing, preparing, administering, and evaluating the effects of medicines. Nurses are the health care professionals who have the most sustained contact with residents, including all aspects of medicines use (both directly and in a supervisory role). This means our members are ideally placed to manage medicines for vulnerable older people, and improve systems and processes that address the issues of polypharmacy, use of antipsychotic medicines, and transitions of care.

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However, the number and skill mix of nursing home care staff is not federally regulated; in many facilities across the country, this has resulted in having too few registered and enrolled nurses to ensure the safe and appropriate administration of medicines, a contributing factor to the 98% of residents who have at least one problem related to medicines.[2] The nursing profession is united in calling for this issue to be addressed in order for our members to be able to deliver the level of skilled, qualified, timely care all people in Australia deserve.

QUM in aged care is contingent on there being an appropriate skill mix and, more specifically, an adequate number of registered nurses (RNs). RNs are the linchpin of quality and safety. They have a critical role in providing clinical nursing leadership and governance. This extends to supporting care staff in nursing homes, ensuring systems are in place to support QUM, undertaking comprehensive assessment of residents, and applying critical thinking to all matters which are relevant to the safe administration of medicines. This is particularly important in the case of polypharmacy and the increasingly complex health care needs of residents within the aged care setting. RNs delegate to, and supervise, enrolled nurses (ENs) and assistants in nursing (AINs). Enrolled nurses have a critical role in aged care but they are required by the Nursing and Midwifery Board of Australia (NMBA) to practice under the delegation and supervision of the RN at all times. Accordingly, it is vital that there are sufficient numbers of RNs to meet the regulatory requirements of delegation and supervision. These responsibilities are outlined in the NMBA *Registered nurse standards for practice*[3], NMBA *Enrolled nurse standards for practice*[4] and NMBA *Decision-making framework*[5].

Quality use of medicines in aged care is contingent on there being adequate staffing levels of RNs, ENs and AINs to meet the assessed care needs of residents.

This response will provide feedback on current initiatives provided by the ANMF to our nurse and AIN members that promote evidenced-based best practice with the aim of optimising the outcomes and wellbeing of older individuals. In addition, this submission will address systemic challenges faced by residents and staff in the aged care sector, including gaps and issues in current processes.

Question 1:

What is considered best practice for QUM and medicines safety in residential aged care in 2020? What works and should be done more? What doesn't work and should be done less?

Current best practice includes the minimisation of risk and harm to older persons, ensuring optimal treatment is provided to address the complex comorbidities associated with older age, improving quality of life and optimising end of life care. When creating strategies that reduce complications associated with polypharmacy, overuse of antipsychotics, and transitions of care, adopting a consistent, person-centred approach to medicines management that can be implemented by qualified, skilled, expert health practitioners can reduce the incidence of medicines error and overprescribing, and facilitate treatments that are individualised.[6]

The ANMF strongly supports QUM within aged care; our *Quality Use of Medicines* position statement outlines to our members the importance of timely and affordable access to medicines for consumers, and the responsibility of nurses and midwives of adhering to medicines management best practice. This responsibility includes maintaining the knowledge and skills to utilise medicines appropriately, being aware of the risks and benefits of each medicine they supply and/or administer, and questioning whether the use of medicines is appropriate in individual cases through discussion and consultation with other health practitioners.

This Position Statement is supported by the ANMF's N*ursing Guidelines for the Management of Medicines in Aged Care*,[8] which explicitly addresses the potential harms and risks associated with polypharmacy and excessive use of psychotropic agents in the aged care setting. It supports QUM by providing evidenced- based guidance on medicines safety through the provision of information regarding storage, appropriate prescribing, dispensing and supply, administration, disposal, documentation and evaluation of medicines.

Supporting nurses including nurse practitioners

Every person receiving aged care services is entitled to QUM through ongoing assessment by a health practitioner who is qualified to assess their clinical condition, which encompasses their physical, mental and socio-emotional status. The ANMF staunchly advocates for and strongly supports the role and scope of nurse practitioners (NPs), who are integral to improving access to evidence-based, safe, effective health and aged care. NPs are well placed to provide therapeutic interventions related to medicines within the aged care sector, including both independent prescribing and de-prescribing. NPs facilitate person-centred care, evaluate care provision, and enhance safety and quality within the health and aged care sectors.

In addition to prescribing, NPs provide comprehensive assessments that identify actual or potential issues, and discontinue medicines when they no longer serve their original purpose, or when the potential harm of continued administration outweighs the benefits. As referenced throughout the discussion paper, the benefits of de-prescribing are widely acknowledged; these include reduced adverse reactions, improved cognition, reduced falls, improved medicines adherence, and improved quality of life. [9]

NPs therefore have a vital role to play in contributing to the reduction of polypharmacy-related risks and adverse outcomes, a QUM national health priority area. However, despite this immense potential, there are very few appropriately-funded NP positions in aged care. While being able to provide a wide range of services, NPs are grossly underutilised in both health and aged care. Any strategy to improve QUM outcomes in nursing homes must therefore include pathways to support a substantial increase in the numbers of RNs enabled to undertake postgraduate study leading to NP endorsement. This requires funding for both preparation and for roles within the sector. The majority of the 2,017 NPs in Australia[10] are ANMF members, and the ANMF will continue to support the growth of this highly qualified and effective nursing workforce.

Support to enable QUM and medicines safety should also be extended to RNs and ENs employed in aged care. RNs have the necessary skills and education to assess the changing care needs of individuals, evaluate their response to medicines, and accurately communicate relevant information to the person, their family, and other members of their health care team. In this way, RNs provide a vital link between the person receiving aged care services and other health practitioners, particularly medical practitioners, pharmacists, ENs and allied health professionals. As previously stated, ENs must work under the direction and supervision of RNs, and practice within legislative and regulatory requirements to safely administer medicines.

As mentioned in the discussion paper, nurses are acknowledged as the key drivers to reduce sedative and antipsychotic use in older people who are experiencing cognitive decline, psychological distress, and/or exhibiting behaviours of concern. This is achieved through implementing individualised non-pharmacological interventions and strategies that have been demonstrated to successfully reduce disruptive and distressing symptoms of dementia.

Knowing the totality of a resident's health status allows for individualised management of behaviours.[12] When caregivers understand the unique needs of individual residents, they can provide activities, routines and conversations that are meaningful for each person, in turn promoting a sense of normality, and preservation of the self. This kind of individualised, person-centred care is synonymous with best-practice, but requires consistency of care, particularly in older people, especially those with dementia, to determine the stimuli that trigger or exacerbate the unwanted symptoms, and/or the interventions that are most effective.

Facilitating this RN and EN knowledge and supporting nurses to do this work, which is the best practice response rather than sedative and antipsychotic medicines use, means addressing issues that allow sufficient time and disrupt continuity, including under-staffing, unbalanced skill mix, and reliance on a casualised workforce, all of which are common in the aged care sector.

Education and Initiatives

Across each of our state and territory Branches, the ANMF provides members with extensive educational opportunities that inform and enhance their practice. This strong focus on continuing professional development encompasses aged care-specific education, including QUM, as the sector comprises a significant portion of the health care system and workforce.

The Aged Care Training Room, run by ANMF's Federal Office, is an e-learning platform that includes medicines management learning activities underpinned by the aged care quality standards and informed by contemporary research. Through our libraries, and our subscription to online peer-reviewed portals such as Research Review Australia, members also have access to current literature that allows them to remain up to date with critical research relating to the aged care sector, and this area of clinical practice.

Our South Australian Branch is the Australian host of the Best Practice Spotlight Organisation, an RN-driven, Ontario-based program that assists health providers implement evidence-based best practice guidelines (BPGs) thereby reducing costs while improving patient and resident outcomes.[13] This program takes a leadership role in BPG development, implementation science and practice, and clinical and healthy work environment evaluation.

The program enables organisations and health systems to focus on patient care and clinical excellence, using the latest research to inform our members' practice and optimise outcomes. Within the program there are approximately 50 Clinical and Healthy Work Environment BPG's, many of which are relevant to the care of people living in nursing homes. Specifically, the transitions of care guideline provides evidence-based recommendations for nurses and other members of the interprofessional team who are assessing and managing people undergoing a care transition. This guideline focuses on assessment, planning, evaluation, education, and organisational policy, and highlights the importance of improved communication between clinicians, residents and across settings, medicines reconciliation, and co-ordination of care.

Question 2:

What are the system wide challenges that need to be addressed?

Medicines management is a complex process with potential for error at every stage from pre-prescription assessment to medicines administration and evaluation. The risk of error is multi-faceted and increases with: the number of medicines prescribed; the number of conditions being treated; the age of the person; their frailty; lack of continuity of medical and nursing care; the use of pre-packaged dose administration aids (DAAs); the number of medicines prepared at each medication time; the number of times a nurse is interrupted while preparing medicines; if medicines are inappropriately crushed or dissolved; if there is difficulty identifying the person who is prescribed the medicines; if the person is not assessed prior to being given the medicines; and if they have any swallowing or digestive difficulties.

Medicines administration in nursing homes is the responsibility of the supervising RN. Yet, despite the high risk of error and resulting harm, medicines administration by RNs is the exception rather than the norm in the majority of nursing homes in Australia. Over the past two decades the number of nurses employed in nursing homes has fallen, with the majority of the aged care workforce made up of unregulated care workers (however titled). While key in providing personal care to residents, these unregulated workers are not educated to administer medicines or legally permitted to do so but are increasingly delegated the role of medicines administration to residents from pharmacy pre-prepared DAAs.

This increasing trend of transferring the provision of nursing care activities, including but not limited to medicines management, from RNs and ENs to these workers is deeply concerning. While this may seem like a more economical option, that perspective accounts only for the task of medicines administration, and takes no account of the essential observational expertise, clinical skill, and theoretical knowledge required for safe, competent, appropriate medicines administration, specifically when working in nursing homes where (given people's complex co-morbidities) the incidence of polypharmacy is high. Directing unqualified care workers to undertake medicines administration, often under the guise of assisting residents (regardless of their degree of dependence or clinical condition) places the health of older people receiving aged care services, unregulated workers, and the RNs who are legally accountable for supervising care, at risk.

Providing individualised, competent care to frail, medically compromised people with multiple co-morbidities and, often, concomitant, cognitive and/or mental health challenges requires experience and expertise. To ensure that people receive safe, quality care, minimum standards of practice must be in place and appropriate regulation is required to reduce the potential for harm for the vulnerable people in nursing homes.

Adequate staffing during high risk transitions of care

Nurses have an essential role in ensuring medicines summaries are current and correct to provide an accurate baseline for assessment and prescribing when residents' transition between health services. To address potential errors occurring during transitions of care, all health services should have admission and discharge procedures in place, inclusive of safe care and quality outcomes. These processes should be aimed at improving communication, handover and follow up for continuity of care of an individual when transferred between services.

Communication gaps can result in a range of medicines errors including administration of ceased medicines, failure to administer newly prescribed medicines, difficulty differentiating or accessing medicines (particularly where they are primarily or solely provided in DAAs), and missed or significantly delayed doses.

Barriers that contribute to a lack of adequate processes during transitions of care include nursing home staffing levels and skill mix that are too low to allow for quality care provision. In many nursing homes, one RN is often responsible for overseeing the care of dozens of medically complex, vulnerable residents; a member survey revealed that in some facilities that number may be as high as 164 residents.[14] These work-load demands can prevent RNs having adequate time to attend to the comprehensive documentation required for effective handover to the health care service, leading to inadequate communication and, subsequently, adverse events during care transitions.

The ANMF has long campaigned for mandated legislated staff ratios to ensure the right number and skill mix of staff, in order to provide timely, quality care that meets the assessed care needs of every person receiving aged care services.

Question 3:

What are the gaps in current processes that inhibit achieving positive patient outcomes/best practice?

The transition from home to a nursing home should be an opportunity to assess and review the person's goals of treatment – what is important to them, what are their priorities, what activities give them pleasure, and what constitutes their idea of a satisfactory quality of life. Person-centred care means the answers to these questions should form the framework of their individualised plan of care. Part of this process should include a thorough review of their medicines, with the aim of discontinuing or changing any medicines that do not directly provide a beneficial pharmacological effect to the person's health and wellbeing.

De-prescribing should also be a part of shifting treatment goals when recipients of aged care services are transferred to or from a health service, following any significant clinical change (such as diagnosis of a life-limiting condition, including dementia), or when they enter the terminal stages of an illness, as de-prescribing may reduce adverse effects and thus improve the person's quality of life.

While receiving palliative care services is not always necessary, care that is informed by a philosophy of prioritising quality of life over length of life or cure will mean fewer medicines, fewer side effects and interactions, and fewer transfers to health care facilities, which are often disruptive and distressing for residents.

To successfully determine and act on the person's priorities takes time, patience, and skilled communication, all of which requires having the right number and mix of staff to achieve.

As pharmacists are rarely available onsite, and doctors (including GPs) visit facilities as needed for specific issues, NPs can make a significant contribution to the health and welfare of nursing home residents and their medicines management. By decreasing the incidence of polypharmacy through reviewing medicine regimes and de-prescribing, the potential for medicines related errors and the adverse effects is reduced.

Question 4:

How should we monitor progress towards quality and safe use of medicines in hospital patients who are residents in aged care facilities?

The ANMF believes that both health and aged care should have universal standards to address the issues associated with quality use of medicines whilst supporting a safe, sustainable aged care sector. Currently, there is a lack of consistency between health care settings and nursing homes, as the latter is no longer categorised as comprising part of the former.

Progress should be directed to regulatory alignment that bridges the gap between the National Safety and Quality Health Service (NSQHS) Standards and Aged Care Quality Standards. While there has recently been work that achieves this goal for organisations that deliver care across both sectors (the NSQHS Standards Multi-Purpose Services Aged Care Module), that does not resolve the problem for residents who transition from nursing homes to health care facilities, and vice versa. Bringing aged care back under the health care umbrella would allow for clinical governance continuity that reduces errors related to care transitions, and ensures that older people receive quality, individualised care wherever they are, and best-practice QUM, optimising residents' care and wellbeing.

Progress can be assessed through gathering statistics on clinical outcomes such as: rates of polypharmacy on admission to, and discharge from, hospital; the incidence of medicines-related side effects, interactions, and adverse reactions in presentations and admissions to acute care facilities; and improved efficacy of medicines reconciliation through regular auditing. This should extend to nursing homes, as pharmaceutical auditing will identify deficits in medicines management, continuity during transitions of care, and encourage ongoing review of individualised medicines management plans.

CONCLUSION

Thank you for this opportunity to provide feedback on this discussion paper on behalf of our members. The ANMF is committed to people in Australia receiving timely, quality, individualised, person-centred nursing and midwifery care regardless of the setting in which this is delivered. A key component of ensuring that those in our care have the best outcomes from QUM. As there are multiple opportunities for errors at every stage of medicines management, any comprehensive improvement of QUM should utilise strategies that address each stage, from assessment to regular review.

As described in this response, the ANMF argues that these strategies must include consistency in standards, which will reduce some of the medicines-related issues that occur during transitions of care. Increasing the contribution of NPs will reduce inconsistencies in documentation during transitions of care, and acknowledge their capacity to review and prescribe medicines which allows for adjustments that are contemporaneous with clinical changes. Most importantly, nurses need the time to assess residents, dispense medicines without interruption, safely delegate administration to appropriately qualified nurses when they are not required or able to administer the medicines themselves, and evaluate the effects of interventions (including medicines) of each resident's clinical condition. RNs and ENs perform these steps, within their scopes of practice, in every other care setting – older people deserve no less, but without the introduction of mandated minimum staffing numbers and skill mix, these vital steps to ensure QUM and medicines safety in nursing homes cannot be taken.

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