Australian Nursing and Midwifery Federation submission to

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE REVIEW OF QUALITY USE OF MEDICINES PUBLICATIONS

GUIDING PRINCIPLES FOR MEDICATION MANAGEMENT IN RESIDENTIAL AGED CARE FACILITIES

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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 300,000 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 feedback on the Australian Commission on Safety and Quality in Healthcare: Updating Quality Use of Medicines Publications – *Guiding principles for medication management in residential aged care facilities*.

The two main areas of concern that the ANMF believes need attention in the review of the *Guiding principles for medication management in residential aged care facilities* is the role of nurses in medicines management and the importance of a mandated staffing and skills mix that meets the assessed needs of residents. The ANMF's position on these two matters and how they should be addressed in the revised guidelines are outlined below.

The role of registered nurses and enrolled nurses in medicines management

Older Australians, particularly those receiving residential aged care services, are characterised by increasing and significant care needs, multiple diagnoses, comorbidities and polypharmacy. It has been estimated that on average they have 3.4 to 4.5 separate diagnoses, 6 comorbidities, and are taking 8.1 medicines.[1]

Further, people over 65 are more likely than any other group to be prescribed a number of medicines,[2] are more sensitive to drug interactions, and more likely to have impaired metabolism and excretion, placing them at a greater risk of receiving a higher than intended dose. The health and cognitive status of older people can deteriorate significantly in response to even small changes in conditions, so medicines (including supplements) must be administered with care, the necessity of each medicine regularly reviewed, and the person receiving care must be monitored for signs and symptoms of interactions and toxicity. Doing this safely requires education, experience, and skill, and therefore needs to be performed by registered and enrolled nurses.[3]

Registered nurses play a key role in safe and effective medicines management, which includes working with prescribers and pharmacies to ensure that medicines are ordered and available for residents, and are stored appropriately, administered correctly and documented. It is the view of the ANMF that there is a distinct difference between administration of, and assistance with, medicines. Only registered nurses, or enrolled nurses, without a Nursing and Midwifery Board of Australia (NMBA) registration notation, working under the supervision and delegation of a registered nurse, have the required education, knowledge and skills to safely administer medicines to frail residents with complex health needs requiring aged care.

The ANMF opposes the disturbing trend in nursing homes of moving medicine administration from registered and enrolled nurses to unregulated care workers. It is the policy of the ANMF that all aspects of medicines management in aged care must be undertaken by registered nurses with elements of the medicines administration process delegated to enrolled nurses where the registered nurse has made the required situational assessment and is available to supervise any such delegation to the enrolled nurse.

This is a regulatory requirement for nurses and the established expected best practice requirement for medicine management in all other health sectors. The ANMF's guidance for nurses in relation to medicines management working in aged care is detailed in the *Nursing Guidelines for Medication Management in Aged Care*.[4]

Mismanagement of medicines continues to feature in the top issues of concern brought forward by the Aged Care Quality and Safety Commission[5] annually. ANMF members also regularly identify medicines management in residential care as a major concern. The guiding principles perpetuate this situation as they provide no clear direction for detailed analysis of the quality use of medicines including safe administration. Nor do they provide safe guidance around the management of medicines for those self-administering their own medicines with assistance of care workers.

The ANMF suggests that safe management of medicines be brought to the fore in the revision of these guidelines to provide clear direction for residents, employers, workers and regulators. The guiding principles should clearly state that registered nurses and enrolled nurses, working under the supervision and delegation of the registered nurse, should administer medicines. The care worker's role in medicines must be limited to assisting older people who have been assessed by the registered nurse as able to self-administer their medicines. A clear definition of self-administration must be provided in the glossary of the revised guiding principles. Where assistance with self-administration is deemed suitable, the guiding principles should also require this to be clearly recorded in the resident plan of care and subject to regular risk-assessment and review. Reference must also be made to ensuring compliance against state and territory drugs and poisons legislation.

Staffing and skills mix

The Royal Commission clearly identified that the aged care workforce is the most critical component of the sector with regard to the delivery of safe, quality care including medicines management. The Commission further recognised that while the sector requires many reform measures to be implemented, safe and quality care for all people in Australia could not be guaranteed unless the chronic, underlying structural workforce issues were addressed. Crucially, this means ensuring an adequate number and skills mix of staff, an issue that the ANMF and its members have been raising for many years.

Low staffing levels and skills mix leads to unacceptable care, poor outcomes, and the experience of neglect and loneliness for older people in aged care.[6 7 8 9 10] Evidence upholds, and common-sense dictates, that to provide safe, quality care, approved providers must have at least the right number of the right kinds of staff to do the work. The Royal Commission agrees, and Recommendation 86 included, a clear directive to legislate minimum staffing levels and skills mix in nursing homes by 1 July 2022 and to raise the minimum standard by 1 July 2024. The recommendation also included the requirement to move from legislated 16-hour per day registered nurse presence from 1 July 2022 toward 24-hour registered nurse presence by 1 July 2024. Low staffing levels and poor skills mix also impacts medicines management and the quality use of medicines in nursing homes, particularly after hours. Often clinical managers are rostered on day shifts leaving afternoon and night shift medicines management, administration and monitoring to chance.

In the Commonwealth Government's response to Recommendation 86,[11] there is a commitment to legislate minimum staffing levels and skills mix in a new Aged Care Act, but only to the Royal Commission's first minimum standard and not until 1 October 2023 and with no commitment to raising it in the future. The Government has also committed to legislating the presence of a registered nurse for 16-hours per day from 1 October 2023, but likewise, has not committed to improving this to 24-hour presence in the future.[12]

The ANMF maintains that neither the Royal Commission's recommendation, nor the Government's commitment go far enough. Both represent staffing levels and skills mix that are too low to ensure that people receive safe, quality, dignified, best-practice care and are deferred for too long to deliver benefit to many older people currently in nursing homes who spend an average of 2 years and six months in residential aged care.

Mandating a minimum standard for staffing levels and skills mix that enables best practice care would mean that all older people in nursing homes would be able to receive safe, effective, dignified care that meets their unique needs and preferences. Having the right number of staff would mean that care is not rushed or missed. Nurses and other care staff would be able to take the time they need to provide respectful, person-centred care and to create and sustain meaningful personal relationships with older people and their family members. Staff could effectively support one another and provide robust clinical care assessments, and handover shared care obligations in collaboration with general practitioners, allied health teams and other relevant health care specialists. Mandatory safe staffing levels and skills mix would also help nursing homes offer high quality clinical placements for nursing students and care worker trainees which would lead to improved attraction and retention of staff in the sector.

It is the position of the ANMF that residents should receive best practice care, not care that is simply 'adequate'. Best practice care could be provided to all residents if nursing homes were required to ensure that every resident receives on average 4.3 hours (258 minutes) of care per day including 77 minutes from registered nurses, 52 minutes from enrolled nurses, and 129 minutes from personal care workers.[13] To provide this level of care, evidence has shown that a nursing home should ensure a skills mix of 30 percent registered nurses, 20 percent enrolled nurses, and 50 percent personal care workers. Anything less than best practice introduces increased risk of harm to residents.

Further, registered nurses are integral to the provision of high quality care and better outcomes for residents.[14] They play a key role in medicines management as outlined above, as they have the knowledge and expertise to implement the quality use of medicines. Registered nurses provide comprehensive clinical assessment pre and post medicine administration, ensure that medicines are ordered and available for residents working with prescribers and pharmacies, are stored appropriately, administered correctly and documented. Many nursing homes do not have a registered nurse onsite on every shift (morning, afternoon, and night) to provide care to residents, supervise other staff, and coordinate handover with visiting health practitioners or specialists including general practitioners and paramedics. Even when one registered nurse is present, this may not be enough to provide safe, best practice care to larger numbers of residents or residents with higher care needs such as those with complex conditions, many co-morbidities, are very sick, have severe dementia, or who require palliative end of life care.

The Royal Commission has recommended that nursing homes should have at least one registered nurse on site for the morning and afternoon shifts (16 hours per day) from mid-2022 and 24 hours a day from mid-2024. The ANMF believes that at least one registered nurse must be onsite at all times, right now and much earlier than mid-2024 and that in many cases, more than one registered nurse will be required. The Australian Government needs to go further to ensure that nursing homes have 24 hour registered nurse presence at a level that is dictated by the residents level of need to deliver safe, best practice care.

To this end, guiding principles for medicines management in nursing homes must consider and stipulate the importance of having a minimum legislated staffing and skills mix level. The guiding principles must clearly articulate the required minimum average minutes per day and, as outlined above, the ANMF recommends the evidence-based minutes per resident of 258 minutes per day, with 77 minutes of care from registered nurses, 52 minutes from enrolled nurses, and 129 minutes from personal care workers. The guiding principles must also identify that registered nurses must be present twenty-four hours per day in all nursing homes for medicines management, administration and the quality use of medicines.

SURVEY QUESTIONS

Guiding Principle (GP) 1 for medication management in residential aged care facilities

GP 1 - Change to:

Clinical governance of medication management

1. GP 1 - Recommendation 1:

Alter the focus of GP 1 to Clinical governance of medication management and broaden the commentary and definition of 'medication management' within GP 1 and the Glossary.

Agree

The ANMF agrees that the focus of this principle should be altered to address clinical governance in medication management. Providing a clinical governance framework that incorporates governance at all levels, from the Board room to point of care is essential in supporting quality use of medicines.

Any clinical governance framework must also include the essential element of staffing. Medicines management cannot be delivered in a safe and effective way without the right number of the right kinds of staff to complete the role. This requires enough registered nurses and enrolled nurses, working under the supervision and delegation of a registered nurse, to meet the assessed needs of residents. The ANMF recommends that all governance requirements must clearly articulate and implement the evidence-based minutes per resident of 258 minutes per day, with 77 minutes of care from registered nurses, 52 minutes from enrolled nurses, and 129 minutes from personal care workers.[15] This must also include the requirement for registered nurses to be present 24 hours per day in all nursing homes.

In regards to the broadening of the commentary and definition of medication management the ANMF supports the inclusion of monitoring relevant clinical indicators.

A clear definition of assisting with self-administration of medicines must also be included in the glossary. This will provide clarity for care workers* who may be involved in supporting people to self-administer their medicines.

*Includes Assistants in Nursing and Personal Care Workers (however titled)

2. GP 1 - Recommendation 2a:

Include relevant reflective questions that aim to improve the composition, structure and governance role/ function of medication Advisory Committees (MACs) including:

a. MACs taking appropriate action within a risk management framework when reviewing RACF results and trends relating to their national mandatory quality indicators on medication management.

Agree

The ANMF supports the inclusion of MACs taking appropriate action framed through a risk management process regarding trends in quality indicators for medicines management. The ANMF does however note that the current guiding principles already outline the requirements to monitor, review and evaluate all aspects of medicines management and this has not been achieved. The ANMF believes that this is due to, in part, the absence of clinical governance processes to support this requirement. It is also intrinsically linked to the underemployment of highly skilled registered nurses in sufficient numbers to undertake safe medication administration and supervise care workers in their limited role of assisting residents when they have been assessed by the registered nurse as suitable to self-administer their medications.

3. GP 1 - Recommendation 2b:

Include relevant reflective questions that aim to improve the composition, structure and governance role/ function of MACs including:

b. MACs proactively monitoring other relevant QUM indicators (including medication-related adverse events and/or incidents; high-risk medicines; polypharmacy) that are used to ensure safe and appropriate use of medicines within the RACF.

Agree

The importance of the MACs proactively monitoring all relevant indicators is essential to improve the quality use of medicines in nursing homes. Registered nurses should be involved in the data collection and review as part of their role in clinical governance. However, this activity should not reduce time allocated for the provision of direct person-centred care.

Advances in digital health technologies including care delivery software and ongoing collection and analytics of data to improve medicines management is essential. It is important to note that many nursing homes do not have the digital health infrastructure required to collect and monitor relevant medicines data. Clear expectations of the required digital infrastructure for data collection and analytics need to also be outlined.

This should include:

- access to information at the point of care;
- sufficient digital health resources for the workforce;
- implementation of software that is interoperable with other systems including the My Health Record; and
- privacy and security policies and processes that are understood and used.

GP 2 - Information Resources

4. GP 2 - Recommendation 1:

That GP 2 is retained.

Agree

5. GP 2 - Recommendation 2:

Adapt content within the Medication Safety Standard relevant to the provision of medicines information and medicines information resources within the residential aged care setting.

Agree

The ANMF agrees with the content of the Medication Safety Standard, particularly Actions 4.11 and 4.13 being included in the guiding principles.

6. GP 2 - Recommendation 3:

Ensure information within GP 2 continues to align with all relevant professional practice standards and that the resource lists are updated.

Agree

Any guidance used to support medicines management must always meet the accepted professional standards set by the regulatory authority for nurses, the Nursing and Midwifery Board of Australia (NMBA) as these are mandatory professional standards for nurses.

An important example of this is the NMBA's *Decision Making Framework for Nurses and Midwives*[16] which clearly identifies the delegation process for nursing activities by the registered nurse to enrolled nurses and unregulated care workers. The current framework identifies a number of factors that a registered nurse must consider using a risk management approach when delegating and supervising aspects of nursing care including medicines management. These requirements must be clearly addressed in the guiding principles to ensure these mandatory regulatory standards can be met.

7. GP 2 - Recommendation 4:

That consideration be given to creating web-based lists of medication information resources in the updated guiding principles, so that these lists can be updated as needed to ensure people and health professionals have access to an up-to-date and centralised list of resources.

Agree

All evidence-based, relevant resources must also be easily accessible for nurses and, where appropriate, care workers. This needs to include adequate internet access for nursing homes and accessible devices for the workforce at the point of care.

8. GP 2 - Recommendation 5:

Multimedia and multi-lingual resources are to be available to cater the needs of target groups of people. For example, people with disability and CALD communities.

Agree

The ANMF supports the importance of multimedia and multi-lingual resources being included in the guiding principles as there needs to be equitable access to information for all, including those from diverse groups.

GP 3 - Selection of Medicines

9. GP 3 - Recommendation 1:

That GP 3 be retained and strengthened with respect to appropriate prescribing, decision-making and medicine selection practices (for example, avoiding inappropriate polypharmacy; deprescribing; and appropriate use of high-risk medicines) and update resource lists.

Agree

Registered nurses have a fundamental role in ensuring quality use of medicines. Any intervention aimed at reducing avoidable hospitalisation, improving antimicrobial stewardship and reducing inappropriate psychotropic medicines use relies on good clinical assessment and judgement from registered nurses providing care to residents and working collaboratively with prescribers. This is particularly important given the high numbers of people with dementia living in nursing homes.

For this reason registered nurses and enrolled nurses, working under the supervision and delegation of a registered nurse, must be working in nursing homes 24 hours per day. The staffing and skills mix must enable registered nurses to meet the assessed needs of residents.

Given the high incidence of chronic conditions, comorbidities and polypharmacy of residents in nursing homes, it is paramount that nurses are involved in development of risk mitigation strategies for medicines management. Nurses are strong advocates for medicines safety and must be involved in medicines and related incident reviews. Nurses must be enabled to drive education programs and development and implementation of policies and protocols to ensure proactive management of high risk medicines.

10. GP 3 - Recommendation 2:

Move some aspects into a new guiding principle entitled 'Scope of practice', which could cover all categories within the RACF workforce.

Agree

The ANMF supports the inclusion of a new principle entitled 'Scope of practice' in the guiding principles. As outlined earlier it is essential that any guidance on medicine management must always meet the accepted professional standards set by the regulatory authority for nurses, the NMBA, as these are mandatory professional standards for nurses. This includes nurses working within their scope of practice.

There also needs to be a separate section that clearly addresses the role of the care worker in assisting residents who have been assessed as suitable to self-administer their medicines.

11. GP 3 - Recommendation 3:

Include the requirement for RACFs to ensure that clinicians 'work within their scope of clinical practice and have the knowledge, skills, competence and delegated regulatory and legal authority to manage, use, and handle and administer medicines'.

Agree

The inclusion of a requirement for all nursing homes to ensure that health practitioners work within their scope of practice outlining the knowledge, skills and competence to handle and administer medicines is supported by the ANMF.

A requirement should also be included in this section which outlines the care worker's role in medicines management being limited to assisting residents who have been assessed by the registered nurse as able to self-administer their medicines. As outlined above, guidance must also be included in this section to emphasise the importance of clinical governance and systems management to enable registered nurses to meet their regulatory responsibilities in regards to the supervision and delegation to enrolled nurses and care workers.

Further the ANMF believes the standard should include a requirement for a sufficient staffing and skills mix that meets the assessed needs of residents to ensure safe selection of medicines and enable registered nurses to work safely within their scope of practice.

GP 4 - Complementary, Alternative and Self-Selected Non-Prescription Medicines

12. GP 4 - Recommendation 1:

That GP 4 is retained.

Agree

13. GP 4 - Recommendation 2:

That GP 4 (as well as GP 2) resource list be updated to include reference to the NHMRC Talking with your patients about Complementary Medicine - a Resource for Clinicians and the PSA Position statement on Complementary medicines.

Agree

GP 5 - Change to: Nurse-initiated medicines

14. GP 5 - Recommendation 1:

That GP 5 is retained and the focus broadened to encompass the situations where initiation of both prescription and non-prescription medicines is allowed or authorised, and renamed Nurse-initiated medicines.

Agree

The recommendation to rename this principle to Nurse-initiated medicines is supported by the ANMF.

The ANMF also notes that the Commission's *National Residential Medication Chart (NRMC3) User Guide for nursing and care staff* outlined in the consultation paper must also follow this recommendation and be retitled- Commission's *National Residential Medication Chart (NRMC3) User Guide for Nurses.* The role of the care worker in quality use of medicines must be limited to assisting residents who have been assessed by the registered nurse as able to self-administer their medicines. Care workers cannot be involved in all elements of medicines management outlined in this document including signing a medication chart when a resident 'receives' medicines from a dose administration aid. This is administration of medicines and using the term receives instead of administration is enabling and perpetuating unsafe practice. The Commission need to take a leadership role to ensure guidance is legally sound and provides transparency on best practice for residents,

the workforce and aged care providers. This will ensure there is no confusion regarding the definition of administration and the importance of quality use of medicines principles being implemented by nationally regulated health practitioners – in this instance nurses.

15. GP 5 - Recommendation 2:

That other existing guiding principles be incorporated under this new 'title', for instance, GP 6 (Standing Orders), which are designed to allow or authorise administration of medicines in particular circumstances.

Agree

GP 6 - Standing Orders

16. GP 6 - Recommendation 1:

That existing GP 6 be incorporated under a renamed GP 5, focused on situations where initiation of both prescription and non-prescription medicines is allowed or authorised.

Agree

Further to statements made above, the ANMF concurs with the current guiding principles that acknowledge that the administration of a medicine using a standing order requires clinical judgement, therefore registered nurses are solely responsible for the use of standing orders in nursing homes. Again, the guiding principle needs to explicitly outline that care workers must be excluded from taking a role in the medicines administration involving standing orders.

GP 7 - Change to: Documentation of medication management

17. GP 7 - Recommendation 1:

That GP 7 is retained and updated to highlight the need for future implementation and use of the eNRMC and updated resources include reference to support materials for the implementation of the eNRMC.

Agree

As outlined in question 3, it is important to note that many nursing homes do not have the digital health infrastructure required including updated interoperable software. The budget allocation of government funding to support the implementation of the digital infrastructure will be useful, however outlining clear expectations that will enable the use of digital medicines management and connection to the My Health Record is essential.

18. GP 7 - Recommendation 2:

That consideration be given to renaming GP 7 to focus on Documentation of medication management, which would encompass both hard-copy and use of digital systems.

Agree

The ANMF supports the renaming of the guiding principle 7 to focus on the documentation of medication management.

GP 8 - Split into two separate guiding principles:

- Medication review

- Medication reconciliation

19. GP 8 - Recommendation 1:

That GP 8 includes information on polypharmacy and deprescribing and consideration of relevant policies, procedures and guidelines on these topics and the relationship with the National Aged Care Mandatory Quality Indicator program.

Agree

As highlighted above, registered nurses are fundamental to safe medicines management for residents including polypharmacy, de-prescribing and medicines review and reconciliation. Registered nurses both initiate a review and provide information on the clinical status of the resident to inform decision-making by the prescriber. As nursing homes are currently not required to provide a registered nurse at all times, the ANMF believes the revised guiding principles must explicitly outline the requirement for registered nurses to be present 24 hours a day to support safe medicines management, in particular medicines administration.

20. GP 8 - Recommendation 2:

That other aspects of medication review and medication reconciliation from various resources, practice standards and guidelines be considered when updating GP 8, for instance, reconciliation against a best possible medication history.

Agree

The nursing homes software systems being interoperable and connected to My Health Record is an important enabler for medicines reconciliation. The implementation of the transfer form that the Australian Digital Health Agency is developing for the My Health Record will also enable more effective communication between

nursing homes and other health services, particularly in regards to medicines management. Therefore, as outlined above, it is essential that nursing homes have the digital infrastructure to enable this to occur.

21. GP 8 - Recommendation 3a:

That GP 8 be split into two discrete guiding principles entitled 'Medication review' and 'Medication reconciliation'.

Agree

The ANMF agrees with dividing this principle into two discrete guiding principles. Medication reviews and medication reconciliations are different processes and the evidence-based requirements for each of these activities need to be clearly identified.

GP 9 - Continuity of medicines supply

22. GP 9 - Recommendation 1:

That GP 9 is retained and that the potential for combination with GP 10 (Emergency Stock of Medicines) be considered given that both have a focus on ensuring medicines are available for administration to people in RACFs.

Agree

GP 10 - Emergency stock of medicines

23. GP 10 - Recommendation 1:

That the intent of GP 10 be retained and consideration be given to combining with GP 9 (Continuity of Medicines Supply) as a potential strategy for ensuring access to relevant medicines to support continuity of supply.

Agree

The ANMF concurs with the intent of GP 9 recommendation 1 being retained and combined with GP 10 recommendation 1. Our members often express frustration about not having access to medicines supply for residents when required. This includes the ability to provide a different dose to a resident at the point of care, or having timely access to medicines for resident requiring end-of-life care. There should be an agreed national minimum requirement of medicines supply for all nursing homes to enable safe medicines management that results in safe and timely quality care delivery.

GP 11 - Storage of medicines

24. GP 11 - Recommendation 1:

That the intent of GP 11 be retained and consideration be given to combining with GP 12 (Disposal of medicines).

Agree

As registered nurses are not consistently available across nursing homes 24 hours per day, this does not ensure there are national safeguards relating to medication safety. An example of where this creates difficulty for our members relates to the storage of medicines. Registered nurses are educated to expect that medicine cupboard keys, particularly those containing S4 and S8 medicines, be held by a registered nurse and handed over to a registered nurse. This is problematic where there is no legislated mandated requirement to have a registered nurse on all shifts. Revised guiding principles should explicitly state the arrangements to be made for safe storage of medicines that ensures registered nurses are working all shifts in a nursing home. The guiding principles must also ensure registered nurses' professional practice is not compromised through these safe storage arrangements.

GP 12 - Disposal of medicines

25. GP 12 - Recommendation 1:

That the intent of GP 12 be retained and consideration be given to combining with GP 11 (Storage of medicines).

Agree

New guiding principle: Administration of medicines within the RACF

26. Recommendation:

That all, or a selection, of GP 13, GP 14, GP 15 and GP 16 be collapsed and combined under a single guiding principle entitled Administration of medicines within the RACF.

Disagree

There is already confusion about the difference between self-administration, assisting with self-administration, and administration of medicines by workers in nursing homes. Such confusion leads to a failure to effectively regulate medicines management in nursing homes and perpetuates role-confusion amongst workers and their employers. Combining guiding principles that relate to both administration of medicines by nurses and

assisting with self-administration by care workers under the heading '*Administration of medicines within the RACF*' will further confuse role boundaries. Administration and assisting with self- administration should remain separate principles. This review of the guiding principles provides a timely opportunity to poor practice creep that has compromised medicines safety and quality use of medicines.

GP 13 - Self-Administration of Medicines

27. GP 13 - Recommendation 1:

For consumers/residents people who are self-administering medicines include advice within policies, procedures and guidelines, for those self-administering and/or nurses, some additional guidance, on when and how to stop and restart medicines during periods of acute illness or "sick days". This may involve the need for nurses to take over the administration of all medicines.

Partly agree

The ANMF notes the increasing evidence regarding the use of medicines on 'sick days' and the need to provide ongoing support and resources for all people self-administering their medicines. This will ensure safe medicine use. Any resource provided for residents regarding sick days and their medicines needs to be developed using plain language with a basic level of assumed knowledge.

Further, as previously stated, the guiding principles need to also include a clear definition of assistance with self-administration of medicines, including the required safeguards relating to risk management and documentation. This additional information will also need to address guidance for residents who are self-administering without assistance, but who then require either assistance with, or administration of medicines during 'sick days'.

As only nurses should be administering medicines, there should be no requirement for guidance that involves nurses "taking over" the administration of all medicines on "sick days".

GP 14 - Administration of medicines by RACF staff

28. GP 14 - Recommendation 1:

Include some additional advice for RACF clinicians and nurses on when and how to stop and restart medicines during periods of acute illness.

Agree

This guiding principle should detail registered nurses' underpinning knowledge, skills, ability and clinical expertise which informs medicines management. This guidance should reinforce that nurses use evidence-based practice and holistic assessment of an individual resident and the use of medicines when a residents health status changes.

GP 15 - Dose administration aids

29. GP 15 - Recommendation 1a:

That GP 15 includes greater emphasis and more information on the need for medication reconciliation prior to DAA packing for the first time, and after changes to medicines or hospital admission.

Agree

Medication reconciliation, matching medicines that a person should be prescribed with those that are prescribed, should occur prior to packing the DAA and following any changes to medicines prescribed. This is a process that should be undertaken by a pharmacist when packaging occurs and by a registered or enrolled nurse when administering medicines from a DAA. In accordance with the ANMF *Nursing Guidelines for Management of Medicines in Aged Care* and the ANMF Position Statement on the U*se of dose administration aids*, nurses who administer medicines from a DAA are expected to take responsibility for identifying each individual medicine prior to administration. This is essential to ensure that the packaged medicines align with the prescribed order and that the correct medicines are administered safely. Where individual medicines cannot be clearly identified, nurses must consult the pharmacist and return the DAA for repackaging.

Where a person is assessed as being unable to self-administer their medicines, either from the original container or a DAA, a nurse who is able to reconcile and identify the medicines must administer them. Care workers should only ever provide physical assistance to an individual who is self-administering their medicine, at the individual's request provided the individual has been assessed by the registered nurse as being able to self-administer.

Transitions of care, particularly hospital admission for an acute episode of care, are often associated with medication changes and medication errors. Medication reconciliation by pharmacists and nurses should occur at all transitions of care where medicines changes may have been made.

GP 15 should detail dispensing, medication reconciliation and administration requirements to provide clarity and guidance to those responsible for these aspects of clinical care when using DAAs, pharmacists and nurses respectively.

30. GP 15 - Recommendation 1b:

That GP 15 includes greater emphasis and more information on the need for consent and communication around initiating and continuing use of DAAs.

Agree

GP 15 should detail the evidence base for and best practice for consent from, and communication with, the person receiving care and their family when initiating and using DAAs. This should include information about the dispensing process, medication reconciliation, possible self-administration, appropriate administration by nurses, any changes to medications and what to expect when the person is unwell or transitions of care occur.

31. GP 15 - Recommendation 1c:

That GP 15 includes greater emphasis and more information on monitoring and follow up of people using DAAs, including how to identify and manage medicines packed in a DAA during acute illness per GP 13 (Self-administration of medicines); and GP 14 (Administration of medicines by RACF staff).

Partly agree

The inclusion of a greater emphasis and more information on monitoring and follow up of people using DAAs in GP 15 is supported. However, should the person self-administering their medicines using a DAA become acutely unwell, following consent from the resident, medicine administration should then be the responsibility of the nurse. Registered nurses and enrolled nurses, working under the supervision and delegation of the registered nurse, are educated to manage and administer medicines safely and effectively and to assess clinical symptoms, evaluate outcomes and initiate changes to the plan of care. All nurses administering medicines from a DAA must be able to identify each individual medicine prior to administration for all residents, irrespective of whether they are well or acutely unwell.

GP 16 - Alteration of oral dose forms

32. GP 16 - Recommendation 1 (a and b):

1. That GP 16 has greater emphasis and includes more information on:

a. the need for people to be screened or assessed for swallowing safety before being given medicines, and

b. timely referral to a pharmacist or the person's primary health care practitioner when it is unsafe for a them to swallow oral formulations of a medicine.

Agree

Increased emphasis and information on swallowing safety and appropriate referral is supported. In addition to timely referral to a pharmacist and primary health care practitioner, GP 16 should include further information about referral to a speech therapist and a dietitian should alteration or reconstitution of medicines be required. Continued inclusion of reference in the guiding principles to the Society of Hospital Pharmacists 4th Edition of the *Don't Rush to Crush* publication is supported.

33. GP 16 - Recommendation 2:

That other content be similarly amended around swallowing difficulties, including: GP 8 (Medication review and medication reconciliation); GP 13 (Self-administration of medicines); and GP 14 (Administration of medicines by RACF staff).

Agree

See comments above in relation to the inclusion of content relating to the broader multidisciplinary team when managing medicines administration for people with conditions that impact their functional ability to swallow. This should apply to all the guiding principles outlined in this question.

GP 17 - Change to: Evaluation and quality improvement

34. GP 17 - Recommendation 1:

That GP 17 (Evaluation of Medication Management) be renamed, and that its quality improvement focus be enhanced and aligned with the intent of a renamed GP 1.

Agree

The renaming, change of focus and re-positioning of GP 17 is supported. This will allow for a very practical approach to the ongoing evaluation of the effectiveness of medication management processes.

35. GP 17 - Recommendation 2:

That the existing 'evaluation' questions be adapted and incorporated as 'reflective questions' where relevant within each guiding principle.

Agree

Adapting the 'evaluation' questions to be 'reflective' questions where relevant throughout the guiding principles will allow for monitoring of the implementation of the principles, within and between-facilities. This will also assist facilities with self-assessment and monitoring against the guiding principles.

Proposed new guiding principles

36. New GP focused on person-centred care - Recommendation

That a new guiding principle focused on 'person-centred care' is included in the updated *Guiding principles for medication management in residential aged care facilities*.

Agree

In addition to the inclusion of a new guiding principle on 'person-centred care', person-centred language should be integrated throughout all other guiding principles in the document.

37. New GP focused on communication - Recommendation:

That a new guiding principle focused on 'communication with people receiving care and the importance of communication between colleagues' is included in the updated *Guiding principles for medication management in residential aged care facilities*.

Agree

In addition to the inclusion of a new guiding principle on communication, both with the person receiving care and between colleagues, it is essential that the guiding principles provide clarity for users as to who has responsibility for each aspect of medicines management. Miscommunication or confusion about roles does not support safe practice and quality use of medicines.

38. Please include your comments on whether the current purpose and scope of the Guiding principles for mediation management in residential aged care facilities need to alter in any way, why and what change(s) you would suggest:

As indicated above, major changes need to be made to GP 13, GP 14 and GP 15 to provide clarity in relation to self-administration of medicines, assistance with self-administration of medicines, administration of medicines and the use of DAAs to administer medicines. The revised guiding principles must provide clear, unambiguous guidance as to who is able to prescribe, dispense, administer or assist with self-administration for the quality use of medicines.

39. Are all the current guiding principles still relevant to medication management within the existing *Guiding principles for medication management in residential aged care facilities*?

Yes

The current guiding principles are still relevant to medication management. The guiding principles relating to administration of medicines must be strengthened to ensure that the guidance is clear and consistent with legislation and regulatory requirements.

40. Are there any gaps or additional GPs that should be included in the updated *Guiding principles for medication management in residential aged care facilities*?

Yes

See responses provided above particularly in relation to GP 13, 14 and 15.

41. Apart from those already identified, could some of the other GPs on similar topics be 'grouped together' when updating *Guiding principles for medication management in residential aged care facilities*?

No

There are no obvious areas where guiding principles could be grouped together. For the purposes of clarity, some of the groupings previously suggested are not supported.

42. Are you satisfied that the areas of importance or increased emphasis in medication management that have been identified, will be incorporated into the GPs as proposed, in updating *Guiding principles for medication management in residential aged care facilities*, in a way that meets your needs?

No

There are a number of outstanding issues raised throughout this response that would need to be addressed.

43. Please provide details of any resource(s) or guidance materials that should be referred to or included when updating the G*uiding principles for medication management in residential aged care facilities*. (This could be in the form of resource titles; reference; website links; case studies; tools; exemplar/new models of practice/care).

The ANMF provides the following resources that should continue to be referred to in the revised guiding principles:

ANMF *Nursing Guidelines for Medicines Management in Aged Care*
ANMF *Quality use of medicines* position statement
ANMF *Use of dose administration aids* position statement
ANMF *Care for people living with a disability* position statement
NMBA D*ecision-making framework for nurses and midwives*
SHPA 4th Edition *Don't Rush to Crush*

44. Does the format of the existing *Guiding principles for medication management in residential aged care facilities meets your needs*?

Yes

45. Are you responding on behalf of your Organisation

Yes

Please provide the name of your Organisation, email address optional if we need to follow up comments:

Australian Nursing and Midwifery Federation

fedsec@anmf.org.au

46. What is your main role in the organisation?

- o Clinical Director/Head of Department
- o Executive (CEO, President, Executive)
- o Chair/member of the RACF Medication Advisory Committee (MAC)
- o Doctor
- o Nurse Practitioner
- o Nurse
- o Pharmacist
- o Member / representative
- o Other (please specify)

- Please specify: National professional and industrial nursing and midwifery member organisation

CONCLUSION

Thank you for the opportunity to provide feedback on the Australian Commission on Safety and Quality in Health Care's consultation - Updating Quality Use of Medicines Publications – *Guiding principles for medication management in residential aged care facilities*. The ANMF supports many of the proposed additions and adjustments outlined in the consultation document. However, we reiterate that these guiding principles must provide clear direction for residents, employers, workers and regulators on the important role of registered nurses and enrolled nurses, working under the supervision and delegation of the registered nurse, in the quality use of medicines. The care worker's role in medicines must also be explicitly identified as being limited to assisting residents who have been assessed as able to self-administer their medicines. Clear definitions of assistance and self-administration must be provided in the glossary of the guiding principles. The ANMF has detailed the importance of a baseline staffing and skill mix that meets the assessed needs of residents to safe medicines management and quality care delivery. We urge you to address this issue in the updated guiding principles. The ANMF looks forward to the next stage of the consultation for the review of the *Guiding principles for medication management in residential aged care facilities*.

REFERENCES

1. Willis E, Price K, Bonner R, et al. 2016. Meeting residents' care needs: A study of the requirement for nursing and personal care staff. Australian Nursing and Midwifery Federation.
2. Maher RL, Hanlon J, Hajjar ER. 2014. Clinical consequences of polypharmacy in elderly. Expert Opin Drug So/.13(l):57-65. doi:1 0.1517/14740338.2013.827660
3. Bretherton A, Day L, Lewis G. 2003. Polypharmacy and older people. Nursing Times. 99(17):54-55: Available online: https:// www.nursingtimes.net/Journals/2012/ll/09/i/r/a/030429Polvpharmacv-and-older-people.pdf
4. Australian Nursing and Midwifery Federation (2012) Management of Medicines in Aged Care. Accessed on 4 September, 2021: http://anmf.org.au/documents/reports/Management_of_Medicines_Guidelines_2013.pdf
5. Aged Care Quality and Safety Commission (2020). Annual report 2019-2020. Available at https://www.agedcarequality.gov.au/ media/88749
6. Bostick JE, Rantz MJ, Flesner MK, Riggs CJ (2006) Systematic review of studies of staffing and quality in nursing homes. J Am Med Dir Assoc. 7(6):366-76.
7. Dellefield ME, Castle NG, McGilton KS, Spilsbury K (2015) The Relationship Between Registered Nurses and Nursing Home Quality: An Integrative Review (2008-2014). Nurs Econ. 33(2):95-108, 116
8. Jeanie Kayser-Jones J, Schell E, Lyons W, Kris AE, Chan J, Beard RL (2003) Factors That Influence End-of-Life Care in Nursing Homes: The Physical Environment, Inadequate Staffing, and Lack of Supervision. Gerontologist. 43(2):76–84.
9. Kalisch BJ, Tschannen D, Lee KH (2011) Do staffing levels predict missed nursing care? Int J Qual Health Care. 23(3):302-8.
10. Kalisch BJ, Xie B, Dabney BW (2014) Am J Med Qual. 29(5):415-22.
11. Ibid.
12. Australian Institute of Health and Welfare (2019) People leaving aged care. GEN Aged Care Data30 June 2019. Australian Government
13. Willis E, Price K, Bonner R, Henderson J, Gibson T, Hurley J, Blackman I, Toffoli L and Currie T (2016) Meeting residents' care needs: A study of the requirement for nursing and personal care staff. Australian Nursing and Midwifery Federation
14. Shin JH, Renaut RA, Reiser M, Lee JY, Tang TY (2021) Increasing Registered Nurse Hours Per Resident Day for Improved Nursing Home Residents' Outcomes Using a Longitudinal Study. Int J Environ Res Public Health. 6;18(2):402
15. Willis E, Price K, Bonner R, Henderson J, Gibson T, Hurley J, Blackman I, Toffoli L and Currie T (2016) Meeting residents' care needs: A study of the requirement for nursing and personal care staff. Australian Nursing and Midwifery Federation
16. Nursing and Midwifery Board of Australia (2020) Decision-making framework for nursing and midwifery. Accessed on 2 September, 2021 https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Frameworks.aspx