ACCPA
Aged & Community Care Providers Association

Submission: Aged Care On-site Pharmacist Measure

September 2022

Contents

About ACCPA

Aged and Community Care Providers Association (ACCPA) is the national Industry Association for aged care providers offering retirement living, seniors housing, residential care, home care, community care and related services.

ACCPA exists to unite aged care providers under a shared vision to enhance the wellbeing of older Australians through a high performing, trusted and sustainable aged care sector. We support our members to provide high quality care and services while amplifying their views and opinions through an authoritative and comprehensive voice to the government, community, and media.

Our sector serves to make better lives for older Australians, and so do we.

1. Introduction

ACCPA welcomes Labor Government's support for the *Aged Care On-site Pharmacist Measure* introduced by the previous government in response to the Royal Commission into Aged Care Quality and Safety Final Report's recommendation, which identified medication management as an area that requires improvement.

Older Australians often suffer from multiple chronic illnesses and therefore use many medicines.[1] In the aged care setting, there are high rates of medicine use by older people, with, on average, individuals using between 9 and 11 different medicines.[2]

According to a review conducted by the Pharmaceutical Society of Australia, over 95% of people living in aged care facilities have at least one problem with their medicines detected at the time of a medicines review; most have three problems.[3]Importantly, the review found that about one in five medicine-related problems were attributed to people living in aged care facilities not receiving a needed medicine, one in five problems were due to an inappropriate medicine selection, and one in six problems were attributed to adverse medicine reactions.

A recent retrospective study[4] (A year-long study of 57,719 individuals aged 65–105 years taking at least one medicine, who entered an RACF (Residential Aged Care Facilities) in three Australian states between 1 January 2012 and 31 December 2015 and spent at least 6 months in the RACF) found that provision of a Residential Medication Management Review (RMMR) in the 6–12 months after RACF entry is associated with a 4.4% lower mortality risk over 12-months.

The study also shows that only 12,603 (21.8%) of residents received a RMMR during the study period.

Having access to an on-site pharmacist will improve medication management and safety (and uptake of RMMRs (residential medication management reviews)) and will give residents and their families confidence that medications are regularly reviewed, appropriate and needed. Importantly having access to on-site advice on medications provides additional support and advice to the clinical team in an aged care facility. But the Government must get the governance structure right to ensure that the program is fit-for-purpose to support resident care.

This submission has been prepared in consultation with ACCPA Members and has been structured to respond to each of the consultation questions, as highlighted in the consultation response template.

---

[1] Page A.T. et al 2019 Polypharmacy among older Australians, 2006-2017: a population-based study. The Medical journal of Australia. 2019;211(2):71-75

[2] Pharmaceutical Society of Australia 2020 Medication safety: Aged care February 2020

[3] Pharmaceutical Society of Australia 2020 Medication safety: Aged care February 2020

[4] Slugget et al 2022 Provision of a comprehensive medicines review is associated with lower mortality risk for residents of aged care facilities: a retrospective cohort study Age and Ageing 2022; 51: 1–11

2. Funding model for employment of on-site pharmacists

Q1. Do you believe funding should be provided directly to residential aged care homes or coordinated through Primary Health Networks (PHNs)? Why is this your recommended funding model?

Funding for on-site pharmacists in residential aged care facilities (RACFs) should be provided direct to residential aged care providers rather than PHNs (noting with PHNs, national aged care providers would be left dealing with multiple PHNs rather than one touch point). This would provide them with more control and ownership of the pharmacy program.

Providers should be able to choose to either employ pharmacists directly or to contract in their services. In thin markets providers may not be able to engage pharmacists despite their best efforts and they should not be penalised in these circumstances.

The ability to contract in pharmacy services would include being able to contract in pharmacy services through a third party provider which is the current model of funding for Quality Use of Medicines (QUM) and Residential Medication Management Review (RMMR) programs.

ACCPA notes direct employment models from RACF are not popular with pharmacists. During the recent Australian Association of Consultant Pharmacy (AACP) annual Consultant Pharmacy Seminar (ConPharm 2022), there was a poll that asked how embedded pharmacist should be funded, 91% chose 'engagement by the aged care facility of an embedded pharmacist with payment provided by the Pharmacy Program Administrator to either an accredited pharmacist, an organisation employing an accredited pharmacist, or a community pharmacy'.

The current system under the 7CPA program that enables individuals or organisations to deliver services, has led most Residential Aged Care Providers (especially those with more than one facility) to specifically choose professional organisations to deliver 7CPA services given the additional quality, service delivery, system benchmarking and reporting benefits that can be delivered.

3. Developing and defining the role of the on-site pharmacist

Q2. What do you see as the key role and responsibilities for an on-site pharmacist in residential aged care homes? Please consider the role in relation to the Medicines Advisory Committee/residential aged care clinical governance

The role and responsibility of the on-site pharmacist needs to incorporate all the elements of the current 7CPA RMMR and QUM programs.

Some key areas of the role include:

- Proactively recognise high risk residents, review, and identify medication-related problems, and discuss with multidisciplinary team members (doctors, nurses, care staff) to reduce medication-related harm and improve the quality use of medicines.
- Collaborate with multidisciplinary team members and resident/representative to put in place strategies to minimise the use of high-risk medications, including psychotropics.
- Audits of medication management systems including review of policies and procedures for medication management.
- Participation in Medication Advisory Committee (MAC) meetings, supporting a multidisciplinary approach to these activities.
- Working collaboratively with the multidisciplinary health team to address antimicrobial stewardship and improve antimicrobials use.
- Responding to medication utilisation reports including medication incidents and adverse events and follow up support for medication management incidents.
- Liaising with other key health providers (GPs) and community pharmacies.
- Acting as an educational resource for residents/family.
- Auditing of prescribing practices, administration practices, and incidents with a view to contributing to the facility's continuous improvement practices.
- Acting as an educational and clinical resource for staff.
- Participating in resident case conferences.
- Be a medicines related information source for residents/substitute decision makers.
- Supporting homes with achieving their Medication Management Mandatory Quality Indicators.
- Providing a clinical lens over medication use in the aged care home and supporting change as part of continuous improvement activities.
- Assistig with vaccination programs.

We believe these responsibilities can best be met when the pharmacist has the right supporting structures and systems around them. In this context, we note that there are already organisations (such as WardMM, Mederev, Choice and Meditrax)) that specialise in medication management that provides a framework in which the pharmacist can best

succeed in delivering medication management and quality use of medicines services to RACFs whist also satisfying audit, government quality and governance obligations.

Q3. How could residential aged care homes or Primary Health Networks be supported in engagement of pharmacists to work in aged care homes? Do you have a suggested approach to engaging pharmacists in rural and more remote locations to work on-site in residential aged care homes under this measure?

While aged care providers should take full responsibility for recruiting and retaining pharmacists in their homes/organisations, we believe they should be supported through the provision of guidance materials by the Department of Health and Aged Care (DHAC) which cover matters such as development of position descriptions for on-site pharmacists, guidance on integrating the pharmacist into the clinical team and recognition of roles and responsibilities of the pharmacist their role and function on medication advisory committees etcetera.

As noted above (Q1) direct employment models by RACFs are not broadly popular with pharmacists. In this context, funding should be provided directly to the service to either directly engage pharmacists or to fund a third party to deliver pharmacy services to the provider.

Rural and remote

Whilst on-site time is important for pharmacists regardless of the location, there is a practical reality with some remote and rural locations that on-site presence may be limited and this needs to be supported through virtual/remote support, RMMR reviews, and remote attendance at MAC meetings etc. In this context we note that Professional Pharmacist organisations have gained experience in the effective delivery of medication management services both on-site and virtually. The need for virtual support became particularly critical for homes affected by COVID.

We believe that engaging pharmacists to work in regional and remote locations to work on-site may require:

- Providing accommodation supports.
- Appropriate remuneration/regional allowance including on-call or after hour allowances.
- Understanding barriers and there may be a need to have a more flexible model.
- Support via the provision of Telehealth and Virtual Pharmacist models (in addition to on-site time wherever possible).

Importantly, the use of digital resident information and electronic National Residential Medication Chart (eNRMC) would be crucial for effective communication to support this model of care.

Q4. How could this relatively new role be promoted to pharmacists to encourage uptake?

For the program to work, it would require attractive remuneration. Importantly, as aged care could be considered the 3rd option as a career pathway for pharmacists (community and hospital being the other two) it is important to have a defined career progression model (including remuneration) based on experience and performance.

The concept of becoming an aged care specialist pharmacist could start in university with a specific module/course that acts as the foundation for this option as a career.

Promotion could occur via advertising on all pharmacy/aged care body websites, employer websites, social media platforms, conferences, pharmacy magazines, newsletters, emails, SMS, letters, radio advertising, networking events, training courses, webinars, early education to high school students as a career option, and at expos.

Q5. How can on-site pharmacists best collaborate with the aged care health care teams (including residents and their families, other staff, the local general practitioner and pharmacy) in regard to transitioning between health care settings?

During transitioning between healthcare settings, on-site pharmacists should be involved in RMMR and/or the medication reconciliation process (to ensure that the resident take medications as prescribed during transition of care) and the handover process including working closely with the resident's regular GP or nurse practitioner or medical specialist on medication-related issues and resolution process to ensure best practice care to meet the needs of the resident. The pharmacist should also attend resident/relative meetings to discuss medication related issues (could have focus sessions on particular topics of concern in the home or from the families).

Importantly, effective communication systems need to be in place to support collaboration between the pharmacist, the aged care service, and prescribers on medication related issues.

Q6. How should continuing professional development, mentoring, and networking for on-site pharmacists be supported and maintained?

While CPD (Continuing Professional Development) could be supported through their peak body and registration requirements, a funding model that provides for the contracting of pharmacists through a third-party provider would allow that third party provider to provide for the pharmacist's ongoing development and professional supports:

- CPD and training courses including:
    - Aged care specific education and training.
    - Practice-based research on quality indicators or evidence-based clinical practice.
    - Drug use evaluation.
- Offer a mentoring program/buddy program when the pharmacist first starts in the role for support – with the opportunity to involve other allied health professionals.

- Shadow/buddy newly credentialled pharmacists or pharmacists working for the first time within an RACF environment, offering valuable insight, experience, and systems familiarity.
- Guided Professional Development – ensure they know what is available for them so they can choose what is most appropriate for their development needs.
- Carve out a career pathway so they can develop accordingly.

4. Training requirements for pharmacists

Q7. What training currently exists that could be adapted to meet training requirements? Can existing training be upscaled if required?

On-site pharmacists would need to be provided with training in a range of matters that all aged care staff that work in RACFs undertake including the requirements of the Serious Incident Response Scheme (SIRS), manual handling, Workplace Health and Safety (WHS), and eNRMC etcetera.

Existing training: Monash University: P4004 - Graduate Certificate of Clinical Pharmacy (Aged Care) is currently available. This training can be upscaled with the following additional essential areas:

- Aged care standards, principle of quality of care and Aged Care Act and related legislation.
- Management of restrictive practice and informed consent process.
- Antimicrobial stewardship in aged care.
- Psychotropics stewardship program: With special focus on benzodiazepines and antipsychotic use.

ACCPA notes Australian Association of Consultant Pharmacy (AACP) training program that could also be adapted includes:

- Accreditation to conduct medication reviews.
- Geriatric pharmacy qualifications.
- Residential Aged Care Pharmacist module run by PSA (Pharmaceutical Society of Australia).

Ideally, newly qualified pharmacists should be clinically ready (but will not be RACF ready) and the Pharmaceutical Society of Australia (PSA) courses should be made mandatory, and pharmacists will then need to have some hands-on experience with a mentor/trainer before being confirmed as "fully competent".

In this context, we note there are Professional Pharmacist Organisations that can support with mentoring and on-site component including shadowing an existing accredited pharmacist.

Q8. What should be the model/provider of national oversight of the training to ensure the ongoing quality of the training, consistency of training across all training providers and maintenance of currency of knowledge once training is completed?

Training organisations would need to be accredited to meet nationally consistent training requirements.

Training/trainers organisations would be audited against these national standards to ensure they are achieving the required training standards. Additionally, a national register of 'Accredited' pharmacists to be RACF pharmacists under the Government's funded scheme, should be established.

Maintaining currency of knowledge would require extra CPD (as is now for accredited pharmacists) but some course/educations would be compulsory to ensure currency of knowledge is maintained, these will need to be developed and, for example, could include case studies.

Importantly, for this model to work, there needs to be well defined quality indicators, a clear governance structure, accountability, and transparency, to show commitment and value.

Q9. How would accredited pharmacists make the transition into the role of an on-site pharmacist in a residential aged care home?

All on-site pharmacists should undergo the aged care organisation's induction training including operation, policy, and procedures.

Those already with experience in aged care would not need more training. Those already providing the QUM and RMMR services would not have issues transitioning. However, it is important to have a minimum standard of service provision which the pharmacist must adhere to in order to maintain their accreditation and this standard of service would need to be agreed upon at a national level.

5. Development of health outcome indicators and associated reporting

Q10. What outcome indicators should be included in addition to the Aged Care Quality Indicators for medication management, e.g. specific indicators on inappropriate antimicrobial use, anticholinergic load reduction?

We believe Antimicrobial (UTI treatment without pathology testing) and PRN charting of antifungals could be included as outcome indicators.

Importantly, revision of the QIs need to be considered given that polypharmacy is just an indication that some residents need a larger number of medicines. Appropriateness of those medications needs to be identified and risk v benefit needs to be investigated further – that

is where medication management reviews, follow ups and case conferencing are invaluable and can support the homes to ensure that the residents are getting the best possible care.

Changing the emphasis would allow for identification of inappropriate use of medications and this could be recorded as a quality indicator.

Q11. Are there any barriers to the on-site pharmacist working with the Medicines Advisory Committee, and if so, how can they be addressed?

There should not be any barriers to an on-site pharmacist working with the services MAC. It is important that these committees are multi-disciplinary with pharmacists embedded within them.

MAC meetings should be conducted with a consistency of agenda items and data that is made available to inform current status, trends and progress against key medication management quality indicators, incidents, risks and ensuring up to date/best practice medication knowledge is made available to RACF clinical leadership.

Whilst the provision of eNRMCs into the RACF will assist in making medication management data available, there are specialist service provider organisations (including WardMM) that could support the on-site pharmacists with clinical support, IT systems, reporting, trend analysis, and benchmarking, thus supporting the pharmacist with the information and knowledge required to be confidently providing best in class, evidence-based input into the MAC meetings.

6. Transition from services funded under the Seventh Community Pharmacy Agreement Pharmacy Programs

Q12. What support will residential aged care homes require with this transition, in addition to the on-site pharmacist?

Aged care homes will need to understand the scope of the on-site pharmacist's role and function enabling them to prepare for the commencement of this program. Understanding the program will help them to prepare for the on-site role putting into place program guidelines, develop a QUM Plan, prepare clinical staff etcetera.

Providers will also need support with training programs, tools (electronic) that pharmacist need such as Therapeutic Guidelines, AMH and MIMs as well as with funding to adapt RACF Client information management systems to create report writing capabilities and National QI reporting.

Alternatively, pharmacist-led organisations that have many years of experience in delivering RMMR and QUM services, could provide support oversight of individual pharmacists, manage recruitment, mandatory compliance, governance, and systems for pharmacists to use.

A funding model that enables such an organisation to continue operating and transition from existing 7CPA agreements to new on-site pharmacist agreements, will ensure a smooth transition of services whilst maintaining medication management quality within the RACFs.

Q13. What is the optimum period of time required for this transition, i.e. how long do you think the Residential Medication Management Review and Quality Use of Medicines Program services funded under the 7CPA Pharmacy Programs should continue at residential aged care facilities that have engaged an on-site pharmacist?

We believe there should be at least a six-month transition period for an individual facility, and up to twelve months for a state or national provider with multiple facilities.

ACCPA understands that it can take a number of months for a pharmacist that is new to the RACF environment to reach a high level of quality in delivering RMMR services (noting that if RMMRs are to be performed, there needs to be a handover from accredited to appropriately qualified pharmacist), and longer before they are fully across all of the QUM activities and requirements for dealing with allied health professionals and organisations involved in the provision of resident health and medication management.

Sourcing the workforce is currently a major concern as the pharmacists need to be trained or re-engaged in this space. There is a shortage nationally of pharmacists across all sectors so until we are allowing overseas trained pharmacists to come to Australia and/or increasing university quotas, this will continue be an issue. In this context, we expect four years would be the optimum time to fully implement on-site pharmacist program.

It is also important to note that, specialist pharmacist organisations noted above provide peer support, management, clinical and IT support, training, and systems to support new starters. System driven databases, reporting, dashboards, and auditing tools are provided to support the pharmacist. An individual pharmacist working independently in a RACF will take longer to operate at the same standard without this supporting structure.