The state of medication in NSW residential aged care
Results of a NSW Nurses & Midwives’ Association member survey
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Who we are

The New South Wales Nurses and Midwives’ Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. Membership comprises of those who perform nursing and midwifery work at all levels including management and education. This includes registered nurses and midwives, enrolled nurses and assistants in nursing (who are unlicensed).

The NSWNMA has approximately 64,500 members, of which over 10,500 work in aged care. Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation (ANMF). Our role is to protect and advance the interests of nurses and midwives and the nursing and midwifery professions. We are also committed to improving standards of patient care and the quality of services in health and aged care services.

This paper is authorised by the Elected Officers of the New South Wales Nurses and Midwives’ Association.

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Introduction

The importance of safe medication management in residential aged care facilities (RACFs) cannot be underestimated. Registered Nurses (RNs), Enrolled Nurses (ENs) and Assistants in Nursing (AINs)* all have a role to play in ensuring that medication practices comply with legal guidelines and cause no harm. However, most people entering aged care now have high care needs in some form1 and increasing prevalence of dementia and end of life care place extra demands on an already over-stretched workforce.

Aged care workers are increasingly being asked to care for people who require complex polypharmacy and make clinical decisions where people lack capacity. There has also been a reduction in the number of people able to self-administer their medications. These factors combined increase the prevalence of adverse drug reactions and medication errors2,3,4,5. Therefore it is vital workers at all levels are given the resources to do their job safely and efficiently.

Government reform has allowed all RACFs to accommodate people with high level complex healthcare needs, including those that do not employ RNs and were never set up to provide high levels of care. Legislation and guidelines determining best practice in relation to medication management have failed to keep pace. This report demonstrates that guidelines designed for unlicensed AINs assisting people to self-administer medications are now irrelevant in RACFs where high care is mainly provided. It is difficult to comprehend how government reforms established to enhance quality of life could overlook the need to ensure safe medication practices are aligned.

Set amongst a background of limited research6 it is unsurprising that medication issues are a top concern for NSWNMA members employed in aged care. This report follows a member survey conducted in 2017 which received over 700 responses. The results show that poor staffing ratios and skills mix in aged care impacts on the ability of nurses to adhere to safe medication practices. In addition, RNs are professionally compromised by lack of clear and relevant legislative guidelines. These factors combined result in avoidable risk to people living in residential aged care. This issue requires immediate action to ensure medication is delivered by the right person, right route and at the right time.

We would like to thank our members who took the time to participate in this survey and share their stories.

MEDICATION ERROR:
Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labelling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.†

* AIN includes those employed as Care Workers (however titled)
† http://www.nccmerp.org/about-medication-errors
Prior to 2014 there was a clear distinction between RACFs accommodating people with low and high care needs. People requiring high level healthcare would be accommodated in nursing homes employing RNs/ENs and AINs. Those with low care needs would be looked after in hostels. Mixed care services also existed, but often in separate buildings with separate staffing arrangements.

Legislation and guidelines for the management of medicines in RACFs assumed that people living in hostels would require minimal assistance to self-administer their medications, and those in nursing homes would require higher levels of assistance. As a result, NSW legislation required nursing homes to employ RNs and ENs to manage peoples’ medication and hostels used Department of Health good practice guidelines to inform practice.

In 2014 Government reform removed the high/low care distinction from federal legislation allowing high care to be provided in all RACFs, including those formerly operating as low care hostels. Since this change was introduced, there has been a steep rise in the number of people with high complex healthcare needs being accommodated in former hostels. However, medications legislation has not been extended to require them to employ RNs and ENs to administer medications.

These changes also resulted in employment of RNs and ENs in former hostels to reflect the increasingly complex healthcare needs of those accommodated. RNs are responsible for supervising and delegating work to AINs who are not required to comply with legislation determining safe medication administration and management. This professionally compromises RNs since they are accountable if delegated tasks are not performed safely.

There are inconsistencies in regulations across the board. Staff are unsure of their roles/scope of practice. There are too many grey areas in policies and procedures. Education packages do not align with practice.

Although all areas are now designated high care (and require that level of intervention), in the former hostel area we still have Cert. IV or Cert. III medication competent care staff giving out medications from Webster packs – this includes regular S8 and S4D medications.

Our facility is dementia specific and our residents have no ability to recognise or understand the medication they are given. If someone is unwell or refuses medication, AINs do not have enough knowledge to know and understand the implications for the resident.

The law needs to be tightened to ensure that medications are administered safely. I constantly raise this within our organisation. When someone has a confirmed diagnosis of dementia, they are not assisted with medications; staff administer.

“...There are inconsistencies in regulations across the board. Staff are unsure of their roles/scope of practice. There are too many grey areas in policies and procedures. Education packages do not align with practice...”

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“...Our facility is dementia specific and our residents have no ability to recognise or understand the medication they are given. If someone is unwell or refuses medication, AINs do not have enough knowledge to know and understand the implications for the resident. The law needs to be tightened to ensure that medications are administered safely. I constantly raise this within our organisation. When someone has a confirmed diagnosis of dementia, they are not assisted with medications; staff administer...”
There has been a decline in the ratio of RNs (including ENs) to unlicensed AINs\textsuperscript{11,12}. This has resulted in RNs often being required to supervise the care of up to 200 residents across multiple sites. The expectation that RNs can safely supervise the delegation of medication administration in these circumstances is unrealistic. Direct clinical oversight of medication management has been further reduced by a recent increase in the use of ‘on-call’ RN services. The acuity of people across the spectrum of RACFs cannot be underestimated and low staffing levels and poor skills mix are endemic\textsuperscript{13}. These factors combined with the absence of legislative safeguards create a climate for disaster.

**With RNs being required to supervise care for up to 200 residents across multiple sites**

The burden of responsibility for ensuring safe practice of unlicensed AINs is at best unrealistic and at worst, potentially dangerous.
Who administers medications in residential aged care facilities?

Department of Health guidelines for medication management state “Nursing staff are most commonly responsible for the administration of medicines in RACFs”. However, the findings of this survey show that AINs are now administering medications, and more are administered by AINs than RNs and ENs. In addition, nurses identified that almost 68% of residents across RACFs are unable to administer their own medication, which suggests administration of medications by AINs is happening on a large scale.

Medications guidelines assume AINs only assist with self-administration and so offer few safeguards for both residents and workers. In addition, almost 50% of all RNs/ENs stated they require clearer guidelines about their responsibilities for supervising medications given by AINs. 55% stated that there should also be an increase in the number of RNs to enable adequate supervision of AINs.
FORMER NURSING HOMES

Results showed that in RACFs formerly classed as nursing homes, **over 50% of medication administration** was undertaken by AIN’s, despite **over 75% of residents in those services requiring total help with medication administration**. This suggests that there is widespread non-compliance with existing NSW state legislation that requires RNs and ENs to administer all medications in these facilities. As a result, although 65% of nurses working across all settings said they were concerned about the administration of medication in their facility, the figure was much higher (90%) for those who work in facilities formerly classed as nursing homes.

More AINs than nurses are giving out medications.

**AIN, RACF (former Nursing Home)**

AINs do not understand medication actions; that the same medication has different names. Carers often dispense tablets by number only, not by checking the name of medication off.

**RN, RACF (former Hostel)**
Department of Health Guidelines require that medication tasks are only assigned to staff who possess medication training and that skills are regularly tested and updated. However, nurses reported that the training provided for AINs was often inadequate and did not prepare them sufficiently for the task in hand. Nurses reported that training focused more on the task of checking tablets and less about the whole process of administration including assessment and evaluation of health status.

Training should focus on the whole person rather than the task to be completed, and include action to take if a resident refuses medication. The prevalence of dementia related illness in RACFs is rising and it is increasingly important that training prepares workers to make decisions should people lack capacity, or refuse medications.

Lack of knowledge about new drugs, and failure to recognise prescribing, dispensing and administration as high-risk activities also contribute to medication errors. Risks could be reduced through further education in areas such as the effects of medication on an ageing metabolism and acquiring a sound knowledge of pharmacokinetics and pharmacodynamics. However, there are no
legislated training requirements for AINs in RACFs to determine the minimum knowledge required. Unsurprisingly, 74% of AINs said they were concerned about making decisions regarding administration of medicines and withholding medications. They also reported huge variances in the training that they receive.

In addition, previous findings show that poor language skills of workers can be a causal factor in medication errors. Whilst RNs and ENs are required to have a standard level of English language competency, there are no such requirements for AINs which can pose a barrier to interpreting written medication instructions and communication flow during the process of administration. It is essential that workers at all levels are able to receive accurate and timely information to reduce the risk of error.

74% of AINs said they were concerned about making decisions regarding administration of medicines and withholding medications.

As AINs we have not been trained properly to know what the medications are and what they do. So we are essentially giving what to our residents?

The RN ordered me to administer (a medication) after she showed me that a medication was the same class of drug as the one written, but was called something different. I was still confused and not sure what I gave the resident.

AINs receive a two day training course and are then accredited to administer medication. This is no substitute for a diploma or degree and the lack of knowledge about how medications work and their side effects, places residents at a high risk of an adverse event.

AINs do not know what the drugs do and what to watch out for e.g. nausea; constipation, dizziness; falls risk increase; blood pressure changes etc.

Simply up-skilling AINs to deliver medications using a task focused approach is inadequate. Current tertiary education for RNs and ENs ensures they receive training on pharmacodynamics and pharmacokinetics. Medication competencies for RNs are measured across a broad spectrum of learning outcomes, recognising it as a fundamental component of holistic clinical care models that include health promotion, clinical decision making and ethics. These skills cannot be taught to AINs as isolated modules within personal care education and it is vital that they receive good quality, safe, and appropriate education.

Medication changes not detected by AINs resulted in a resident being administered two different high dose antidepressants for three months before an RN (called in to do a AIN medication shift because they couldn’t find a AIN) detected the error. AINs can also administer wrong doses of Warfarin because they are not required to check the dose.

Our facility is changing to medication credentialed care assistants. Only two days training is given to them.

Recent poor training of AINs in medication administration has increased the potential for errors as most staff just count the number of boxes ticked on the chart then count the number of pills popped out of the pack – short term meds often get missed, patches are replaced without removing the previous days patch. AINs are so busy that if a resident with dementia initially refuses meds, they don’t get a second chance and meds are discarded.
Although some AINs said the training they had received was useful, nurses reported variation in the quality of existing training. **54% said that standardised and accredited medication training for all AINs is required.** With no mandated competencies there is little governance of this area and consequently, few safeguards for people.

I’m a Cert. 4 carer and was strongly encouraged to complete the course. Many others that are new to the industry do a simple medication competency and are giving out meds; they do not know what the medications are for, how to read med charts, abbreviations, look for reactions to new medications or check that the current order is validated by a doctor.

“**We are trained medication competent, and any concerns we may have we can choose to complete more training or not give medications at all.**”

“**We had to do a medication course which was very poorly run. We do not want to give medications out.**”

54% of nurses said that **standardised and accredited medication training for all AINs is required.**
Staffing and Skills mix

Lack of time was identified as a major causal factor in medication errors reported by nurses. 64% of nurses stated that having more time to administer medications would improve safety. Recent research suggests RACFs provide half the required numbers of RNs, ENs and AINs to provide safe care and prevent omissions in care episodes13.

To prevent distraction errors it is imperative staff are not disturbed during medication administration14. Previous studies have also shown that interruptions during medications rounds are frequently reported16, with the secondary task of direct care duties being among the most common cause15,17. A previous review of medication errors leading to hospitalisations or death from nursing home residents showed that distraction or incorrect documentation resulted in up to 70% of drug errors. Nursing homes with more than 150 beds had almost twice as many reported errors, although factors such as scale would need to be considered18. Staffing shortfalls were also identified as a contributory factor, particularly on the morning shift16.

At times there is a delay due to nurse to resident ratios. At the moment after hours there is one RN to 153 residents. There could be a delay in terms of medication if the RN is clinical busy with another declining resident, falls etc.

In a 100+ bed facility, RNs are pushed to the limit to get S8 medications out on time, especially on the PM shift as they have to act as receptionist as well taking many calls from relatives. Doctors turning up in the middle of an S8 round, resident falls etc. all take up so much time.
Medication administration errors are inevitable under current practices as staff are constantly interrupted and distracted during medications rounds, which are large and complex. Some residents need complex strategies to assist them in taking their medications and it may take up to 30 minutes to complete for one resident. Management are insisting on unreasonable time frames for medication rounds and in the rush mistakes are made. Increasing sick leave resulting from high workloads and added responsibilities results in an increase in agency staff, and inexperienced ENs and recently graduated RNs who are working under pressure and unprepared.

We are a small facility and have only one RN on duty on afternoon shift, night shift and weekend shifts. RNs become busy on the nursing home side of the facility and are not always available, nor can we find them, when a resident needs an S8 drug.

Usually our RNs have about an hour and a half to administer medications to 50 residents. That’s 1.8 minutes per resident to give medications! It’s unacceptable.

One RN for 60+ residents and sometimes one RN for 120+ residents.

At times, particularly on evening, there can be a shortage of qualified staff to administer medications. An RN has been required to administer medications to 60 residents.

I’m concerned about medications being given too late and the gap between morning and lunch time too short. For example, I have more than 30 residents to give medication in the morning, including tablets, puffers, eye drops, liquid/powder medications and at the same time blood glucose monitoring and insulins, and checking S8 patches. Because I’m the only RN I always get interrupted to check on residents, answer phone calls, attend staff concerns about a resident and to give PRN medications… all of these while I’m doing the medication rounds. I start at 7.15 am and am expected to finish at 10 am.
Commonwealth legislation does not mandate minimum levels of staffing and skills mix in RACFs. Therefore, the provision of RNs relies either on associated State legislation, or aged care provider discretion. Recently, despite rising acuity across all categories of RACFs, there have been models of care introduced that rely on peripatetic, remote or on-call RN provision. This can result in extended periods, particularly during the night or weekends, where an on site RN is unavailable to administer pain relief to residents. This is particularly concerning in remote areas where the RN may live several kilometres away. Nurses told us that this has a detrimental effect on resident outcomes and almost 80% said that having a RN on site at all times would improve the quality of medication management.

It is difficult to go home after working an evening shift when handover is to an AIN as they cannot give ‘as required’ meds. Consequently, it has become almost standard practice to manipulate timing of administration of meds so that a last dose of ‘as required’ analgesia is given just before going home. Often this is not the timing that would be best for the resident – but it is the best we can do for them under the current system. Not good when you are palliating someone.

Would a registered nurse on site at all times improve the quality of medication management in RACFs? (INCLUDING FORMER HOSTELS)

| Yes | 78.83% |
| No  | 11.70% |
| Unsure | 9.47% |

(NSWNMA survey)

‘When palliating a resident there is a delay in providing medication for break through pain and restlessness because there is no RN on duty after hours, so therefore the carer rings the RN to come in to do this and in my case I live 30mins away.’

‘I believe you need an RN on site at all times. They should be the one administering the insulin and handling S8 medication. You also need an RN on hand to be able to handle questions or raise concerns you may have with medications or the way they are charted and administered. If a resident has a reaction to a medication or if a medication error occurs, RNs can assist in what to do.’
Is it safe to crush?

Many nurses linked medication errors to either crushing tablets when it was not appropriate, or not crushing tablets when required. Previous studies have found that crushing or altering medications is commonplace in RACFs with high care residents having the potential for detrimental outcomes, such as increased toxicity or decreased efficacy2,19,20. In one study, 32% of crushed tablets observed were reported as unsuitable for crushing in clinical guidelines5. Competing demands, time and availability of alternatives were influential factors2,19,20.

Increasing staff knowledge has been identified as a major factor for improvement4,19,21 and can reduce the amount of medications that are modified22. Increasing staffing levels have also been cited as a possible improvement since busy, distracted and tired nurses contributed to the incidence of errors15.

The crushing of medication is not limited to RACFs. Research into Queensland hospitals also shows that 88% of medications were modified prior to being administered to patients with swallowing difficulties, calling for increased education by pharmacists and more consideration of prescribing alternative forms by doctors. Solid forms are preferred because they are cheaper, tend to have better physiochemical stability and reduce dosage errors23.

Toxicity can occur through immediate release of slow release products and chemical instability by altering the physical structure of the tablet2. There can also be loss of content through the crushing or alteration process reducing the dosage of medications. This is particularly important for those with a narrow therapeutic index where loss of dose may

§ “Don’t Rush to Crush” is available from MIMS online.
reduce efficacy that could inadvertently be attributed to lack of effectiveness, leading to over prescribing.

Although cytotoxic medications carry warning labels they can be packaged in pre-dosed sachets (Webster Packs), which is often seen as a safer way to handle medicines. However, lack of pharmacological training for all workers, time and poor supervision means these medications could be modified without knowing the associated hazards. Modification of medications with cytotoxic properties would be more suitably undertaken in the pharmacy department than by workers at the bedside and can be potentially dangerous for workers due to risk of secondary exposure.

Crushing medications has the potential to adversely affect patients and contravene legal and professional guidelines. It is recommended that as a minimum, before crushing tablets, a practitioner considers if a pharmacist has been consulted about the appropriateness; whether a liquid or soluble alternative is not available; and if the prescribing GP has approved the practice for that medication where there is no alternative.

It is clear that there needs to be widespread multi-disciplinary education regarding the issue of crushing medication and that the lack of governance of this area needs to be addressed.

Medications are automatically administered from a Webster pack without registered staff knowing what they are giving and why. It is not checked. I recently found a resident had been administered cytotoxic medications since admission and no-one realised.

RN, RACF
Lack of governance

Medication errors are one of the most reported clinical incidents in acute settings, with significance being greater since most are preventable. This survey highlights that the incidence in residential aged care is also a significant issue with 83% of nurses reporting that they have witnessed a medication error.

Medication errors consisted of wrong dosage, wrong resident and omissions. Qualitative responses highlighted a range of causal factors, including incorrectly packaged medications, lack of time and insufficient training and supervision.

Have you witnessed any medication errors in residential aged care facilities?

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(NSWMA survey)

First shift of an AIN administering medication, she gave the wrong medication to a resident, despite photo on med chart and sachet box...obviously did not do all the checks. I have also seen them attempting incorrect method of administration. They frequently sign for patches on medication charts but don’t apply them, i.e. GTN patches or checking S8 patches are in-situ only to have other carers tell me the patch is missing or they found it in the bed. There is also the administering of eye drops, ointments and inhalers that are out of date.

EN, RACF

Far too many to list, for example: medications given to wrong residents; wrong doses; ceased medications being given; double doses when records have not been signed; poorly written prescriptions with doses that can be misinterpreted; crushing medications that shouldn’t be crushed. Also many of the medication packs are not correctly packed and we find many errors.

RN, RACF

I would say my residential aged care facility (100 beds) would make at least one medication error a day.

AIN, RACF (former Hostel)
85% of the witnessed errors were reported and this was generally viewed as a non-threatening and supportive process.

Although few serious adverse outcomes caused by errors were reported, quantitative findings suggest many had the potential to be dangerous, or affect quality of life. Extra training and monitoring were the most common forms of response. However, in a few instances this led to dismissal or inappropriate management which could be a barrier to future reporting. Further training is required at management level to increase safeguards.

Qualitative data showed that RNs tended to be the ones reporting errors; either because they had observed or made the error, or because it had been reported to them by the AIN. This result may be attributable to the fact that unlike AINs, RNs have a professional duty to report. This suggests there are fewer safeguards for those RACFs that do not employ RNs and ENs.

RN/EN picked up the error and reported it to the Facility Manager and Clinical Lead. The medication error form was completed. It was reviewed and the person who made the error was counselled.

There has been little research conducted about the prevalence of medication errors in former hostels compared to high care RACFs. Those that have been conducted were inconclusive. Regardless of setting, medication errors can lead to reduction in quality of life and inability to function normally and it is essential that prompt remedial action is taken.
Medication monitoring was largely seen as a visual process. Checks on missing signatures were common, whereas errors in packaging were more likely to go undetected for some time. Errors identified through direct observation were seen as unlikely due to low ratios of RNs and ENs in the workplace. RNs cited lack of time to make adequate checks on medications entering the RACF; and AINs lack training in this area. This further exacerbates the over-reliance on correct packaging by community pharmacists who may also be inadequately trained.

Most medications were delivered and stored in individual packaging in doses of daily or weekly supplies. This should make the administration of medications a reasonably safe activity. However, a large number of nurses reported errors in packaging with 42% stating that correct dispensing by the supplying pharmacy would assist in reducing medication errors. This does little to support the argument that there are few clinical decisions that are required when using individually packaged and pre-dosed systems.

Although dose-administration aids can reduce errors and save time, there have been concerns regarding over-reliance on pre-packed dosage systems. Issues such as missing doses, poor labelling and incorrect dosing have all been identified as frequently contributing to medication errors. Problems have also been encountered as a result of limited space to attach warning labels; similar looking medications contained within packaging and labelling being inconsistent with the prescription and medication administration record, making it difficult to tell which are correct. Evidence from this survey suggests that this is still a major concern in RACFs.
Webster packs are assumed to be correct when sometimes there are cancelled medications still inside and therefore given. PRN meds possibly aren’t given/ offered as they are required, as less qualified staff aren’t as knowledgeable regarding their role, for example with analgesia.

Medications have been found incorrectly packed by pharmacy or updates/changes by GP not attended. Ceased medications have been contained. When doses have been changed, double the dose has been given when the new dose is delivered but the ceased dose is not marked ceased or removed.

With Webster pack systems in place there is room for error. On occasions where a tablet does not match the supplied picture or description, the pharmacist has stated it is just a different brand. There is never a way to be sure it is correct and the AIN does not always pick these things up as they are trained to count tablets, not identify them.

The pharmacy has sent the wrong dose, or Webster packs, or medications not coming from pharmacy resulting in the wrong medications given to residents.

It is difficult for the RN to check and keep track. S8 meds are packed and administered by AINs.

AIN’s are not legally required to identify tablets (only counting – and seldom that!!!). As a consequence, any pharmacy errors are often missed. Staff who are able to differentiate, may only be rostered on weekends, resulting in mis-administration of medication for around five days.
Electronic medication records are being implemented to improve safety. However, this is not without its challenges. Previous research found adverse consequences, such as inadequate information about the resident, delays in uploading information and omissions due to power outages, which were also evident in these findings.

Medication advisory committees are recommended for all RACFs but there is no legislation to require this in those formerly classed as Hostels. These facilities also lack professional oversight of RNs and ENs. This is a serious safety omission, which requires urgent review given the rising acuity of people accommodated.

The Aged Care Complaints Commissioner reported that medications management was among the top five areas of complaints received during 2015/16 and among the top areas referred to the Department of Health for action by the Australian Aged Care Quality Agency (AACQA). However, there appears to be a lack of accountability at all levels in ensuring this situation is resolved. 37% of nurses stated that the AACQA could regulate this area more effectively, and this would increase safety of medication management.

Mismanagement of medications should trigger immediate remedial action at the highest level, yet the situation remains critical for many older people living in residential aged care. Regardless of classification of facility, the principle remains the same that residents receive the right medication at the right time by the right route.

"We double check Webster packs against the medication chart and the "tough book" (electronic medication list). Most of the time this gadget plays up and causes delay.

RN, RACF"
The implications of getting it wrong

Nurses reported a catalogue of omissions resulting from poor medication management. Over 60% of nurses stated they have experienced a delay in acquiring pain relief and other essential medications for a resident due to no RN on the premises.

Is there ever a delay in acquiring a suitably qualified staff member to administer injectable medications or ‘as required’ s8 medications?

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(NSWNMA survey)

This appeared to be a particular problem in RACFs that were former Hostels, and where there has never been a legal requirement to provide an RN on site at all times. Leaving residents in pain due to unnecessary delays in acquiring the right skill mix of staff not only contravenes residents’ human rights and is an abusive practice, it also places RNs’ registration at risk.

Inadequate pain relief was one of a series of reported omissions or errors arising from either inadequate medications training or shortfalls in staffing and skills mix. The scenarios provided by nurses are concerning and suggest urgent action is required to address the systemic problems in RACFs.

I have seen this happen time and time again. I have witnessed residents have to wait long periods for insulin, because the RN on duty was busy elsewhere. This has meant that the residents have not been able to eat, as BSL has needed to be checked prior to insulin being given.

I have also seen S8 medication delayed for a resident who was palliative. Family members had to go and demand that the medication was given as the resident was in pain, even though there were standing Doctors Orders in place regarding administration. Not good enough.

“
Yes, (residents are waiting for pain relief) frequently at my facility, as RNs are on duty during six to eight hour day shifts only. Care staff must contact the on-call RN, or wait for their arrival. This is a major problem due to high incidence of terminal/palliatiing residents, requiring clinical assessment and appropriate medication that is responsive to presenting symptoms.

Yes (there are delays in getting pain relief). Our facility does not have 24 hour RN care. An RN works 8am-4.30pm.

There can be a delay (in acquiring pain relief) because only one RN is on duty looking after 70 plus residents. It’s sad, but people have to wait, even the dying for palliation meds, injections etc.

With one RN for 75 residents, if there was a problem that needed RN attention (life threatening situation) then the RN would not be available to give out an S8 until perhaps hours later.

There is only one RN to cover three areas in the aged care facility where I work. It is very busy and often the medication needs to be checked for a patient and administered in an area where there is not an RN at that time, which means the resident sometimes has to wait (for pain relief) for up to half hour or more.

We had a lady who had a seizure and continued to fit until the RN could come to the facility to give an IM injection (approximately 30 minutes)

AINs don’t understand what they are giving. The RN (who has to oversee the care of 80 residents) can’t possibly know what meds are being given to each resident. Recently we had a case where a resident had chronic diarrhoea for days. The RN had instructed to omit the many aperients the resident was on, but they were given every day for three days, as the carer didn’t understand the message. The RN thought they were being withheld. Just one small example of many.
Ointments have been applied incorrectly and very poor management of aperients and anti-diarrhoea medications have caused complications. Pain management is greatly improved with an RN on site. Simple things, like if a resident sleeps in quite late, the carer is unsure whether to give breakfast medications, lunch medications or both and is unable to understand the medications enough to make accurate decisions themselves.

I was working in a RACF where AIN’s were giving out meds. I saw ear drops being put in eyes, creams being applied inappropriately and tablets would go missing.

Wrong drug was given to a resident, which was a beta-blocker. The person ended up in hospital.

Medication was put in the resident’s food, and then staff walk away and another resident eats that food. Medication is given whole when it clearly states it is to be crushed.
Conclusion

The process of administering medicines to older people is a serious and complex procedure and not merely a simplified task to be undertaken with minimal training and supervision. The nature and complexities of ageing physiology combined with increased need for complex polypharmacy means there are multiple clinical decisions required before, during and after administration. It is a high risk activity and must be treated as such, regardless of setting.

It is clear AINs are now required to do more than assist people to self-administer their medications. Yet the administration of medications by AINs appears to be overlooked in legislation and guidelines. This report provides clear evidence that RNs and ENs are the most appropriate workers to manage and administer medications across the spectrum of RACFs.

There must be clearer guidelines for RNs to refer to when delegating medication tasks to AINs that extend far beyond existing good practice guidelines. To suggest that an RN or EN has sufficient time during their span of duty to safely provide direction to, or supervise AINs assisting with self-administration is naïve at best and at worst, potentially dangerous.

Medication safety for people living in RACFs is essential. Without this we are exposing them to preventable risk; inappropriate end of life pain relief and possibly, premature death. This report provides clear evidence that links resident safety to safe staffing and skills mix in aged care.

It is vital that urgent action is taken to ensure older people in NSW aged care facilities have access to a skilled and prepared workforce with legislative protections for the safe management of medications. The findings in this report identify a wealth of opportunity for malpractice and litigation. Urgent systemic improvements in all aged care facilities are required to ensure medication management is safe and appropriate for the protection of residents, and the nurses who care for them.
The state of medication in NSW residential aged care

Registered Nurses should be on site at all times to administer medications for people who are unable to self-administer.

The law should only allow RNs and ENs to administer medication.

Standardised and accredited medication training for all AINs/Careworkers.

Clearer guidelines for RNs/ENs about their responsibilities for supervision of medications given by AINs.

The number of Registered Nurses on site should be increased to improve supervision of AINs/Careworkers.

What could be done to make the management of medication in residential aged care safer?

- More time to be able to manage medications during a shift: 64.73%
- The number of Registered Nurses on site should be increased to improve supervision of AINs/Careworkers: 55.91%
- Standardised and accredited medication training for all AINs/Careworkers: 54.85%
- Clearer guidelines for RNs/ENs about their responsibilities for supervision of medications given by AINs: 49.74%
- The law should only allow RNs and ENs to administer medication: 49.21%
- Registered Nurses should be on site at all times to administer medications for people who are unable to self-administer: 43.92%
- Blister packs are dispensed correctly by the pharmacist: 42.50%
- Enhanced checks of this area by the Australian Aged Care Quality Agency during site visits: 37.04%
- Medication prescriptions received are completed fully to enable safe administration at all times: 26.46%
- Differences between administration and assistance should be clearer within self-administration guidelines: 24.16%
- Nothing, I think it is safe: 1.23%
References


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Results of a NSW Nurses & Midwives’ Association member survey

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