Response to:
Australian Commission on Safety and Quality in Healthcare: Updating Quality Use of Medicines Publications.

Updating the Guiding Principles to achieve continuity in medication management.

DECEMBER 2021

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Foreword

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

The NSWNMA has approximately 73,000 members, of which approximately 10,000 are employed in aged care, and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

NSWNMA exists to be a strong, influential union of members respected as a contemporary leader in society for its innovation and achievements. We welcome the opportunity to provide a response to this consultation.

This response is authorised by the elected officers of the New South Wales Nurses and Midwives' Association

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Introduction

The NSW Nurses and Midwives' Association considers the safe use of medicines to be a key issue in community settings. Medication safety has consistently ranked in the top areas of concern with the Aged Care Quality and Safety Commission (ACQSC) and is a top area of concern for our members employed in both residential aged care and other community settings[1].

The Australian Commission for Safety and Quality in Healthcare (ACSQHC) has an excellent track record in determining safe standards of best practice in relation to the quality use of medicines (QUM) in the healthcare sector. We believe it is wholly appropriate the ACSQHC also has oversight of standards relating to safe use of medicines in the community and hope this consultation will deliver enhanced protections for older people.

However, we cannot see the benefit of duplicating guidance when existing National Safety and Quality Health Service (NSQHS) Standards could easily be modified and applied. Indeed, given that health care is widely delivered in residential aged care settings, it is entirely appropriate to have a consistent set of standards across all services where health care is delivered. This creates a level playing field and equality in service provision for consumers.

Our members in NSW are already let down by the current disconnect between state and commonwealth legislation and guidelines. A situation exacerbated when the *Living Longer, Living Better* aged care reforms removed the distinction between high and low care. Registered nurses employed in community settings, including residential aged care constantly find themselves professionally compromised owing to the lack of clarity arising from the different rules around medication management.

We firmly believe there should be a single expectation around medication management across the commonwealth, both in relation to legislation and guidance and hope the review of these guidelines will assist in providing clarity for aged care workers. Our aim is to seek uniform agreement to a universal definition clarifying the difference between assisting and administering of medication. We believe this would provide workers, employers, and regulators ability to determine the role of registered nurse, and enrolled nurse working under their direction, and assistants in nursing/care workers in relation to medicines management.

[1] NSWNMA (2017) *The state of medication in NSW residential aged care: Results of a NSW Nurses and Midwives' Association member survey*. Available at: https://www.nswnma.asn.au/wp-content/uploads/2017/12/Medication-in-NSW-RAS-FINAL-LR.pdf

It is also our position that administration of medicine in the context of residential aged care, where most people require complex healthcare to be delivered, is a nursing role, and that assistants in nursing/care workers role should be restricted to assisting with self-administration only. We also advocate for a clear definition as to what constitutes self-administration and clear guidance in relation to risk-management. Both of which have been lacking from both the commonwealth guidelines and Quality Standards, leading to workers having to self-determine where their role boundaries lie.

Whilst we welcome this review of the guidance, it will have little impact on our members unless it is supported through legislation. We call for enhanced guidance around medication safety to be included in any review of the *Aged Care Act 1997 (Cwlth)* and associated legislative instruments. We also call for alignment between commonwealth and state legislation, and uniformity in guidelines across health and aged care services.

Context in NSW

There is an underlying assumption embedded within the consultation and proposed guiding principles that registered nurses are responsible for managing medications across community settings including residential aged care facilities (RACF).

The reality in NSW is only RACF providing high care prior to 1 July 2014 are required by NSW legislation to have a registered nurse on site at all times and appoint a Director of Nursing to oversee clinical governance.

The market-share of those that fall outside the scope of NSW legislation increases annually and is estimated to be around 40% of the total. Staffing decisions for those falling outside the scope of NSW legislation are made by registered providers. Consequently, not all RACF in NSW have a registered nurse on site at all times, particularly overnight and at weekends and public holidays.

In addition, those falling outside the scope of NSW legislation are not required to adhere to NSW Poisons and Therapeutic Goods legislation. This requires all prescribed s4 and above medication to be administered by an authorised person, being in this circumstance a registered nurse or enrolled nurse working under the direction of a registered nurse.

The outcome in NSW is a significant number of NSW RACF do not have a nurse available at all times to safely manage and administer medicines. In this circumstance it is the commonwealth guidelines, not state legislation, that determines best practice.

The NSW Nurses and Midwives' Association has been lobbying for the NSW legislation to be extended to require all RACF to have at least one registered nurse on site at all times and employ a Director of Nursing. We have also lobbied for the NSW Poisons and Therapeutic Goods legislation to be extended to capture all RACF.

We firmly believe the new Aged Care Act and associated legislation needs to provide clarity in relation to the role of registered nurses and care workers in the quality use of medicines (QUM). We believe it needs to clearly define the difference between *administration of* and *assisting with* in relation to medicines. It also needs to clearly define the scope of self-administration.

Our position is that only registered nurses or enrolled nurses working under the direction of a registered nurse have the required knowledge and skills to safely administer medicines in the context of residential aged care, and that management of medicines is a nursing function. Assistants in

nursing/care workers have a valuable role, but one which must be restricted to assisting residents with self-administration only.

Whilst we accept the commonwealth guidelines do require review, we believe this should occur following detailed inclusion of medicines management in the new Aged Care Act and associated legislation and not in advance of this. This will provide clarity for our members and inform guiding principles.

Responses to specific recommendations

Proposed featured themes

1 Collaboration and care-coordination within the health system – Agree in principle

Whilst we agree with the heightened focus on collaboration and care-coordination we question whether current staffing and skills mix across the breadth of residential aged care settings provides sufficient scope to enable compliance.

There is an absolute need to ensure inter-disciplinary communication and provide timely records on transfer between care settings. However, as stated in our introduction, not all settings in NSW employ registered nurses and enrolled nurses at all times. This means those able to access My Health Record may not be present at all times to input required data at point of transfer. We would therefore advise caution on over-reliance on electronic records as a measure of success.

In addition, our members report in some areas of NSW, internet coverage is poor meaning they are unable to universally rely on electronic medications records.

Current untenable workloads of one registered nurse to 80 or more residents means they are time-poor. Whilst they recognise and comply with the need to ensure accurate and timely record keeping, we would not want additional demands on their time imposed which may set them on a trajectory towards non-compliance through no fault of their own.

Recommended change/inclusion: We advise caution in the application of these changes given current staffing and skills mix may not enable compliance or lead to unreasonable demands on workers to achieve compliance. We also recommend scoping is undertaken to establish how well My Health Record and EMRs are embedded in community aged care settings.

2 Person-centred care – Agree in principle

We are pleased to see recognition that health inequalities exist in relation to digital health literacy, particularly in CaLD communities and rural areas where internet access can be problematic. We again refer to the underlying assumption of the availability of registered nurses to deliver on this proposed theme. Whilst we concur with the content of the proposed changes, it is unrealistic given not all residential aged care settings employ registered nurses at all times.

It would be unrealistic, and inappropriate to delegate the transfer of information to patients/residents around quality use of medicines, including risk mitigation options to lower level workers such as assistants in nursing, or in many cases, care service employees. It is worth noting there are no minimum training requirements for this level of worker, training is determined by their employer.

Recommended change/inclusion: The theme needs to be re-framed to provide for circumstances where a registered nurse is not employed at all times to support health literacy.

Proposed additional guiding principle

3 Patient Safety and Quality Systems – Agree in principle

We believe this addition would be invaluable as a guiding principle. However, we do not believe there is scope for widespread compliance unless there is a legislative requirement for safe levels of staffing and skills mix in residential aged care facilities. All the elements described against this guiding principle require workers with the necessary skills and qualifications to support effective transfer and receipt of information during transitions between care settings and identify risk.

A workforce that relies either on peripatetic or part-time professional input, or which requires nurses to work within such untenable workloads they are unable to provide the level of clinical oversight required will result in widespread non-compliance. The role of registered nurses in these circumstances should be clearly articulated so unachievable expectations are not placed upon them.

Recommended change/inclusion: The guiding principle should recognise existing staffing structures in some residential aged care settings do facilitate compliance and be re-framed to clearly articulate the arrangements to be made in the absence of a registered nurse, or to ensure they do not place unrealistic expectations on already over stretched registered nurses and enrolled nurses.

Review of existing guiding principles

GP 1 Leadership for medication management – Agree in principle

It is unclear how the proposed changes will be operationalised since there are differing legislative requirements covering different types of residential aged care facility, hospitals and even dependent on the status of the residential aged care facility when *Living Longer, Living Better* aged care reforms were enacted. This already creates difficulty for workers, employers and regulators. It is a difficult space to navigate and therefore attempts to align governance could be problematic and will require in-depth knowledge of those facilities to which an individual organisation has integrated governance.

Leadership of medications management is already an area of concern, being a top area for complaints brought to the Aged care Quality and Safety Commission[2]. This is in part due to complex and inadequate medicines legislation, but also as a result of a systematic removal of registered nurses from the staffing cohort and replacement with care service employees, who themselves are under-resourced. Given the current context, it is unclear how this guiding principle can be met

We believe fundamentally, having a single legislative framework across all facilities where healthcare is delivered, including residential aged care and hospitals would create a much safer platform for quality use of medicines. In addition, this guiding principle will require a much higher level of clinical oversight than currently exists.

Recommended change/inclusion: The development of a single legislative framework across all facilities where healthcare is delivered would provide better public protections. Consideration is also required as to how this principle will be achieved given existing low levels of clinical oversight in residential aged care and other community settings.

GP 2 Responsibility for medication management – Agree in principle

We are pleased to see organisational culture and workforce has been considered in the proposed changes to this guiding principle. However, we believe there is insufficient detail provided in the rationale to make informed judgements regarding how well these changes will support aged care workers to manage medicines safely. Again, we suggest this guiding principle has not accounted for services that do not employ registered nurses and enrolled nurses at all times.

Whilst we concur pharmacists have an important role to play in relation to medicines management, we believe this should not be an easy fix to plug the skills shortfalls in residential aged care. Registered nurses have a vital role to play, being directly responsible for care delivery they have the greatest

[2] https://www.agedcarequality.gov.au/sites/default/files/media/ACQSC_AR2019-20_FULL_FINAL.pdf

understanding of the persons care needs. They need to be available in sufficient numbers to enable them to work collaboratively with the pharmacist and GP to ensure quality use of medicines in this context.

Recommended change/inclusion: There should be enhanced detail around expected measures against organisational culture, workforce and training requirements.

GP 3 Accountability for medication management – Agree in principle/with enhancements

In merging these two existing guiding principles the valuable information contained within the existing guiding principle three around who should and should not administer medications must be retained and expanded to provide clarity in relation to the role of registered nurses and care workers in the quality use of medicines. We believe it needs to clearly define the difference between *administration of* and *assisting with* in relation to medicines. It also needs to clearly define the scope of self-administration.

As articulated in our introduction, current legislative ambiguity is used as rationale for what we consider, widespread unsafe medications practices which leave potential to professionally compromise registered nurses and enrolled nurses and leaves assistants in nursing with unfair additional responsibilities beyond their level of training.

Recommended change/inclusion: revised guidelines, including any merged guidance must explicitly state the arrangements to be made relative to administration of medicines and assistance with self-administration to ensure registered nurses' professional practice is not compromised through any proposals.

GP 4 Accurate medication history – Agree in principle

Support this change, noting the previous concerns regarding access to registered nurses and issues related to internet coverage and digital health records.

GP 5 Assessment of current medication management – Agree in principle

Support this change, noting the previous concerns regarding access to registered nurses and issues related to internet coverage and digital health records.

GP 6 Assessment of current medication management – Agree in principle

We believe it is important a medication management plan includes action required to ensure medication safety where a registered nurse is unavailable at a residential aged care facility. Our members report many instances where their employers have chosen not to roster registered nurses and enrolled nurses over night shifts and weekends, including public holidays. This has led to delays in

acquiring pain relief, or as required medications having to be prescribed at regular intervals so they can be packaged in pre-dosed packaging and administered by unlicensed assistants in nursing/care service employees.

The Federal Government response to the Royal Commission into Aged Care Quality and Safety only committed to registered nurses being available 16 hours a day. Therefore, decisions around the staffing of the remaining eight hours will fall to employers. Registered nurses already face dilemmas when expected to delegate medication related tasks, given lack of clarity around legislation regarding when a person may or may not receive prescribed medication administered by an unlicensed worker.

We re-affirm our position that the administration of medication in the context of residential aged care must be undertaken by an authorised person, namely a registered nurse, or enrolled nurse under the supervision of a registered nurse. Any medicines management plan must be informed by guiding principles that make this clear.

The existing guiding principle acknowledges the significance of recognising when a person can longer self-administer their own medication with support. We would like any revision to go further, to clearly outline organisational accountability to ensure they have the correct workforce, available in sufficient numbers, to safely administer medications.

Recommended change/inclusion: revised guidelines must explicitly state the arrangements to be made relative to administration of medicines and assistance with self-administration to ensure registered nurses' professional practice is not compromised through any proposals.

GP 7 Supply of medicines information to consumers – Agree in principle

Support this change, noting the previous concerns regarding issues related to internet coverage to access information sources.

GP 8 Ongoing access to medicines – Agree in principle

Support this change, noting there has been evidence to suggest Dose Administration Aids (DAA) are not a fail-safe method and have been found to contain packaging errors[3], further highlighting the need for workers with a higher level of pharmaceutical knowledge to retain responsibility for administration of medicines in settings where DAAs are used.

Our members report it is often the responsibility of the registered nurse to check DAAs entering the residential aged care facility owing to errors in packaging. Whilst these errors are not the responsibility

[3] https://www.safetyandquality.gov.au/sites/default/files/migrated/lit-review.pdf

of registered nurses, they do have a responsibility to check the medicine is correct prior to administration. This requires a clinical assessment and judgement and is just one part of the five 'R's of safe medicines administration registered nurses are trained to consider as part of the process of administration.

GP 9 Communicating medicines information – Agree in principle

Support this change, noting the previous concerns regarding access to internet coverage and digital health records.

GP 10 Evaluation of medication management – Agree in principle

Whilst we agree the focus should be on quality improvement, some fundamental questions are not included, for example, availability of appropriately qualified and skilled workers to safely administer medicines in a timely manner.

However, as a general comment we believe there is duplication with other Quality Use of Medicines guidance currently under review, and we are concerned duplication will result in overload for an already over stretched workforce.

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