australian nursing federation

Submission to Australia's Health Pty Ltd in response to the consultation paper on The Medication Management in Residential Aged Care Facilities Project

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1. Introduction

Established in 1924, the Australian Nursing Federation (ANF) is the largest professional and industrial organisation in Australia for nurses, midwives, and assistants in nursing, with Branches in each State and Territory of Australia. The core business for the ANF is the professional and industrial representation of our members and the professions of nursing and midwifery.

The ANF has a membership of over 200,000 nurses, midwives and assistants in nursing. Our members are employed in a wide range of settings in urban, regional, rural and remote locations, in both the public and private health and aged care sectors.

The ANF participates in the development of policy relating to: nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare; health and aged care, including reform agendas, community services, veterans' affairs, occupational health and safety, industrial relations, social justice, human rights, immigration and migration, foreign affairs and law reform.

As a member of the former Australian Pharmaceutical Advisory Council (APAC), the ANF was actively involved in the development of the *Guidelines for medication management in residential aged care facilities* (first published in 1997). Included in that document is a set of specific guidelines: *Nursing Guidelines for the Management of Medicines in an Aged Care Setting*, written under the auspices of the ANF, Royal College of Nursing, Australia and Geriaction (the latter organisation was disbanded in 2009). First published in 1996 as a standalone document (to which the ANF holds copyright), the nursing guidelines have undergone three iterations in the intervening years, with a further review currently underway.

Feedback from ANF members demonstrates the usefulness to staff in residential aged care facilities of both the APAC document and the nursing guidelines. The ANF therefore welcomes the current project being undertaken by Australia's Health Pty Ltd to review the APAC guidelines for the Department of Health and Ageing. The ANF Federal Officer appreciated the opportunity to participate in the review through a telephone interview with the consultants. The written submission to follow further contributes to the review process by reiterating some points already raised with the consultants and offering further advice (including updates on statistics previously forwarded).

2. General comments

2.1 Tripartite approach

A major strength of the original APAC Guidelines document was that it brought together the three principle players who can influence quality use of medicines in the residential aged care sector: nurses, medical practitioners and pharmacists. The concept of a partnership approach to medicines management was reiterated through agreed recommendations and appendices which included specific guidelines for each of these health professional groups.

The latest edition of the APAC Guidelines document (November 2002, 3rd edition) does not include the medical practitioner specific guidelines. The ANF continues to support the tripartite approach and urges the Department of Health and Ageing to accommodate timeframes which will allow for the revision and inclusion of each of the three specific guideline documents into the newly created medicines management guidelines.

2.2 Quality use of medicines in residential aged care facilities

The ANF is committed to promoting quality use of medicines in residential aged care facilities where frail older people are most often requiring partial or full assistance with their medicines use. The ANF's position in relation to residential aged care facilities is encapsulated in the following statement from the introduction to the *Nursing Guidelines for the Management of Medicines in an Aged Care Setting*:[1]

> *Medicines, while making a significant contribution to the treatment of ill health and the prevention of disease, to increasing life expectancy and improving health outcomes, have the potential to cause harm. The quality use of medicines requires that the appropriate medicine is prescribed; that it be available at a price the individual can afford; and that it be prescribed, dispensed and administered correctly. The goal of any medicine service for older people is to promote quality of life (p.81).*

It is the view of the ANF that safe, quality care, reinforced by accreditation and funding reporting requirements for aged care facilities demands a safe medicines management system. All aged care services must have clear policies and procedures in relation to responsibilities for the prescription, supply, administration, storage and disposal of medicines. Similarly all aged care services must have systems and resources available and accessible to nursing staff to enable them to implement and adhere to legislation, policies and procedures, and to identify and resolve problems in relation to the prescription, administration, initiation, and adjustment of medicines.[2]

However, there are barriers to quality use of medicines in residential aged care facilities. For example, polypharmacy, excessive use of tranquillisers and psychotropic agents, lack of processes for medicines review, and the administration of medicines by unqualified or inappropriately qualified staff, all pose risks to the quality use of medicines in residential aged care settings. Administration of medicines by unqualified staff or inappropriately qualified staff not only leads to increased risk for error, but also to an unacceptable situation where staff - who lack the requisite educational underpinning - are not able to identify adverse reactions or harmful side effects of medicines that require nursing and/or medical intervention.

The altered pharmacokinetic and pharmacodynamic changes associated with age and polypharmacy in older people require the specific pharmacological knowledge and skills of qualified health professionals including registered nurses, enrolled nurses (see 2.3 below), pharmacists and medical practitioners for the safe management of medicines in aged care settings. The quality use of medicines goes beyond the administration of medicines and must include formal processes for evaluation of clinical outcomes and review of medicines prescribed.

2.3 Enrolled nurses and medicines administration

The APAC model as outlined in the Guidelines document (p. 10) states that, in cases where older people are unable to self-administer, registered nurses or authorised enrolled nurses are the most appropriate professionals to administer medicines, in residential aged care facilities. The ANF advises the term 'authorised enrolled nurse' is no longer correct. Under the *Health Practitioner Regulation National Law Act 2009* (the National Law) there is no endorsement for medicine administration by enrolled nurses. All enrolled nurses who have successfully undertaken a related and accredited program of study are able to administer medications. Under the National Law, all enrolled nurses may administer medicines except for those who have a notation on the register against their name which reads *'Does not hold Board-approved qualification in administration of medicines'*.[3] The revised guidelines document therefore needs to be amended to reflect this changed regulatory requirement.

Enrolled nurses work under the direction and supervision of registered nurses. The education of registered nurses enables them to be aware of the benefits and potential hazards in the use of medicines and to administer medicines safely, as well as monitor their efficacy and any adverse effects. Additionally, registered nurses have the necessary skills to assess the changing needs of the older person and their care; evaluate the person's response to medicines; and accurately communicate that information. In this way, registered nurses provide a vital link between the older person and other health professionals such as a medical practitioner and a pharmacist.

There are differences in state and territory drugs and controlled substances legislation relating to enrolled nurses and medicines administration. The Guidelines document should clearly state the requirement for employers and facility staff to be well informed about their particular state/territory and national legislation as well as professional scopes of practice. Further, that enrolled nurses should not be directed to practice outside of these requirements.

3. Specific comments against consultation questions

3.1 Key influences on medication management in residential aged care facilities at present and likely to emerge in the future.

A1 *What current or emerging factors influence medication management processes within residential aged care facilities?*

The ANF contends that a major emerging factor in the management of medicines within residential aged care facilities is the increased intensity of nursing care at a time when registered and enrolled nursing numbers have diminished. Much of the nursing care is being provided by unlicensed health workers, who may or may not have the qualifications or skills commensurate with the complex care needs of the residents, including those with dementia and other mental health conditions or who require palliative care.

Residential aged care is meeting the care needs of an increasingly more dependent group of people. By far, the majority of residents at 30 June 2009 were assessed as high-care (75%) (p.viii). By way of contrast, 60.8% of residents were classified as high-care in 1999 (p 154).[4]

The numbers of residential aged care places increased by 2,500 in the twelve month period from 30 June 2008 to 30 June 2009 (p viii). The age profile of the resident population continues to increase. Over half (55.4%) of the 158,885 permanent residents at 30 June 2009 were aged 85 years or older, and over one-quarter (26%) were aged 95-99 years (p.53). Overall, only 3% of residents were 65-69 years of age (p.35).[4]

At the same time as there are growing numbers of residents with heightened levels of dependency and increased acuity, the numbers of registered and enrolled nurses employed in residential aged care has fallen from 36,510 in 1997 to 31,136 in 2008, a decline of 5,347.[5] This significant decline in the number of registered nurses has resulted in substantial skill loss from the residential aged care sector, and this, combined with the increase in dependency levels, places further pressure on this sector.

A2 *What are the barriers or enablers to the quality use of medicines within residential aged care facilities?*

With the foregoing in mind, a barrier to the quality use of medicines in residential aged care facilities then is that registered and enrolled nurses are progressively being substituted by assistants in nursing (AINs, however titled). These care workers are now representing the bulk of the workforce providing aged care services. The National Institute of Labour Studies (NLS) report of 2008[6] says that

> *There has been something of a rebalancing of the workforce towards greater use of Personal Carers, and reduced reliance on Registered Nurses (RNs). Between 2003 and 2007, total employment of RNs fell by about 1,600 to 22,400, while PC employment rose by about 17,500 to nearly 85,000.*

This change in skills mix means that there is less access for these workers to support and supervision from registered and enrolled nurses. Also, there are fewer people qualified in medication management to evaluate the effects of medicines taken, especially where there have been changes to regimes or dosages. Another aspect is that with the move to larger more 'economically viable' facilities this has, in certain circumstances, meant that even when there are registered nurses on the roster they are now responsible for a greater number of residents (which can go into the hundreds), making it impossible for real evaluation and medicines management to occur.

An additional issue relating to AINs is the variability in the Certificate III and IV training courses which creates difficulties for registered nurses in the assurance of level of competence when delegating aspects of care.

The ANF is currently running a major national campaign to improve funding levels and skills mix within aged care facilities across the country. Titled *Because We Care*[7] this campaign is attempting to address the aged care workforce issues through four key aims:

- The right balance of skills and nursing hours so that nursing and care staff can provide quality care for every resident
- Fair pay for aged care nurses and care staff who are paid up to $300 per week less than nurses in other sectors
- Recognition of the professional skills of Assistants in Nursing and care staff through a national licensing system
- A guarantee that taxpayer funding is used for nursing and personal care for each resident.

The ANF considers that the achievement of these aims would result in an improvement in the quality of care (and this includes better medicines management) for older Australians.

The ANF is of the view that positive outcomes for residents of aged care facilities are directly related to the quality and quantity of care they receive. High quality residential aged care directly correlates to the skills and education associated with people who provide that care, namely registered nurses, enrolled nurses and assistants in nursing (however titled).

Another barrier to quality use of medicines in the residential aged care sector is that increasingly AINs are required to administer medicines to clients, often without the necessary education and skills. These medicines are most often in prefilled packages dispensed by a pharmacist or more likely a pharmacist's assistant. The onus is on the employer to ensure staff have the skills to provide medicines to the client and to act if there is a reaction to medicines, or to know when not to give medicines. If there is only one registered or enrolled nurse for 60 or more residents, supervision and support of AIN staff is limited. It appears that there are employers who are prepared to take a risk when it comes to medicines management.

The ANF maintains it is imperative for AINs to have a level of education and skill to be involved in the quality use of medicines. Similarly that they be required to continue to update their knowledge, as is the case for registered and enrolled nurses as regulated professionals, to ensure safe and competent practice. It is for this reason the ANF argues for licensing of AINs so that they are governed by the same professional practice framework as registered and enrolled nurses.

Practising within this framework would ensure: a minimum level of knowledge and education; a minimum requirement for ongoing professional development; a minimum standard of nursing care and the establishment of a mechanism for accountability; a process for protection of the public; legal action can be taken with regard to those whose conduct and/or competence is less than the required standard; the establishment of nationally consistent professional standards of competence; the application of fair and transparent assessment for those applying for a license to practise as assistants of nursing; the identification of a scope of practice for assistants in nursing; the provision of a process to inform people receiving nursing care from assistants in nursing that the worker is safe and competent to provide the care; and safeguards for registered nurses who are working with assistants in nursing to delegate particular aspects of nursing care appropriately.

The implementation of a professional practice framework for AINs would also act as an enabler for the quality use of medicines in the aged care environment.

Other enablers of quality use of medicines are:

- Enrolled nurses: All graduates of current enrolled nurse programs have undertaken medicines management within their preparatory education program. In addition, many enrolled nurses have completed medication management modules where this was not a part of their initial education program. This means that enrolled nurses are now able to play a significant role in quality use of medicines in aged care facilities, according to state/territory legislation.

- Nurse Practitioner role: Nurse Practitioner positions are becoming more prevalent within the aged care sector. These health professionals can influence improved medicines practices in a variety of ways including: advising and mentoring other nurses; assessing current practices; evaluating effects of medicine regimes; reviewing medicine regimes; liaising with health professional colleagues involved in resident care such as medical practitioners and pharmacists; prescribing medicines; titrating doses of medicines prescribed; and ceasing medicines where indicated.

- Interim residential care medicine administration chart: Implementation of an interim residential care medicine administration chart (IRCMAC) into the aged care sector. An IRCMAC is a medicines administration chart prepared by a hospital pharmacist (not signed by a prescribing practitioner) to cover a seven day period. This electronically generated IRCMAC is linked to the discharge medicine dispensing process and is an effective tool for streamlining handover of medicine management and reducing medicine errors. The IRCMAC enables medicines to be safely administered and recorded as soon as a resident arrives at the residential care facility, reducing the need for urgent attendance of the prescribing practitioner for the sole purpose of writing a medicine chart, or, of the resident's medication regime being potentially compromised by delays to obtaining required medicines. The IRCMAC is currently in the workplan for the Australian Commission for Safety and Quality in Health Care for national implementation, where this is permissible under state/territory drugs and controlled substances legislation.

- E-prescribing: The advent of e-prescribing. When this occurs across the aged care sector it will facilitate streamlining of prescribing and procurement of medicines for more timely administration (either for continuation of medicines or commencement of new medicines for a resident).

- Communication: Communication processes within an aged care facility can strongly influence quality use of medicines. Where there are clearly identified lines of responsibility and communication these will act as enablers for positive medicines management.

- Documentation: Similar to the previous point, where there are unambiguous policies and procedures relating to documentation of medicines administration, this will be an enabler for the quality use of medicines.

A3 *How do these issues relate to the current Guidelines?*

The current guidelines need to be updated to reflect and ensure medicines safety in light of the issues outlined in the above commentary, especially those relating to changed staffing profiles.

3.2 The Introduction and Preamble

B1 *Are changes required to the Introduction or Preamble to the Guidelines (Yes/No)?*

The ANF considers that changes are required to the Introduction and Preamble to the APAC Guidelines document.

B2 *If yes, what should be changed in the Introduction or Preamble?*

B3 *What is the evidence supporting a change to the Introduction or Preamble?*

The suggested changes, and evidence, are as follows:

- It is now time to remove reference to APAC and the Working Party. While APAC did a vast amount of significant work it is now some time since the disbanding of that national group. Reference could be made to the current national bodies involved in quality use of medicines such as the National Medicines Policy Committee and sub committees as information for the reader. The Preamble in particular will need extensive revision to remove APAC references.

- There needs to be a strong emphasis on quality use of medicines as the motivator for the document, and to stress the importance within the residential aged care sector of the need for best practice in the management of medicines. Frail older people and their families/carers need the reassurance that medicines regimes are monitored for effectiveness of maintaining/improving quality of life as opposed to contributing to deterioration and frailty. That is, that medicines are serving a genuine and positive purpose and not causing harm, particularly where there are fluctuations in a resident's condition.

- Include reference to Nurse Practitioners in the introductory section and everywhere else in the document where health professionals are identified. The Nurse Practitioner role has become well established since the APAC Guidelines document was first published, and is proving especially beneficial in the residential aged care sector. See commentary below under 3.2.2.

- Remove last two paragraphs in the Introduction section and rewrite the 'note to third edition section. These updates are necessary for currency of information.

- Update the profile of residential aged care facilities (RACFs) as shown on bottom of page 3 in the Preamble. The age and dependency profile of residents in aged care facilities has changed, as outlined in section 3.1 above.

- Highlight the profession specific guidelines more in the introductory section of the document. While there is brief mention of these in the Introduction as being appendices, these are significant documents for the three professional groups and deserve a higher profile in the revised Guidelines document.

- Remove Geriaction from the organisations responsible for the nursing guidelines as this organisation has disbanded.

- Check all date references to see if they need to be updated. For example, has there been a revision of the National Health and Medical Research Council's *General Guidelines for Medical Practitioner on Providing Information to Patients* (1993)?

- It is vital that early in the Guidelines document there is a message about the importance of approved providers of residential aged care facilities ensuring their policies are based on a detailed knowledge and adherence to federal and state/territory legislation and professional codes and standards required for registered health professionals (nurses, medical practitioners, pharmacists).

It may be that in the revision of the Introduction and Preamble sections it becomes obvious that these could be collapsed into one introductory piece.

3.2.2 The Nurse Practitioner in residential aged care facilities

Nurse practitioners are registered nurses with the education and extensive experience required to perform in an advanced clinical role. A nurse practitioner's scope of practice extends beyond that of the registered nurse, and is a complementary role to that of registered nurses. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations.[8]

Legislation introduced on 1 November 2010 provides for nurse practitioners to access Medicare Benefits Schedule rebates and Pharmaceutical Benefits Scheme subsidies on medicines for their clients. The scope of practice for the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practise. Nurse practitioners now work in aged care, across residential and community settings.

When prescribing medicines, authorised nurse practitioners must meet the same rigorous standard of care that applies to authorised medical practitioners and registered dentists. Additionally, in aged care settings, nurse practitioners have an important role in educating service providers, consumers and other nurses about the quality use of medicines; being involved in quality improvement activities, including the review and evaluation of medicine systems; and providing support and direction to registered nurses and enrolled nurses in the administration and quality use of medicines.

There are now nurse practitioners in the aged care sector in most States and Territories. With their clinical expertise in the care of older people, these health professionals are making a significant contribution to the care of the elderly. A prime example is Debbie Deasey who works on the north coast of New South Wales, which has one of the highest concentrations of older Australians.[9] Through working with the local residential aged care facilities, Debbie has been able to help older people avoid traumatic hospital admissions. The NSW Department of Health has estimated Debbie's work has saved the hospital $1.5 million in hospital admissions for the over 65s.

A nurse practitioner project conducted in the ACT and concluding in 2007, resulted in two nurse practitioners being authorised to practice in the aged care sector.[9,10] The Executive Summary to that report states that:

> *…the Nurse Practitioners have established their roles and scope of practice, diversified and expanded their services. They … developed new strategies for timely interventions in health care delivery to the aged…These activities, plans and strategies have resulted in significant achievements which (sic) include:*
>
> - *reduction in hospital admissions from residential aged care facilities and the community*
> - *reduction in re-admission rates following discharge from acute care hospitals*
> - *reduction in presentations to emergency departments from aged care facilities*
> - *improvement in the management of end of life care*
> - *reduction in falls in the residential aged care*
> - *decreased incidence of pressure areas*
> - *successful introduction of a clinic for rapid assessment of the aged at risk of hospital admission*
> - *early identification of 'at risk' patients discharged from the acute care setting to the community.*

The Nurse Practitioners also:

- *established successful collaborative working relationships with medical staff and multidisciplinary teams*
- *provided clinical and professional leadership to nursing*
- *significantly contributed to the design and development of new strategies to meet the health care needs of the aged across the continuum of care.*

The above examples are provided as evidence of the positive contribution to the care of the elderly by nurse practitioners and highlight the expert nature of their practice. The revision of the APAC Guidelines needs to take account of the role of nurse practitioners in aged care with inclusion throughout the document.

The ANF stresses that the role of nurse practitioners enhances and co-ordinates the care provided by the nursing team (registered nurses, enrolled nurses, assistants in nursing). That is, the nurse practitioner role is a distinct role and complementary to that of registered nurses in the residential aged care sector.

3.3 The existing recommendations in the Guidelines

C1 *Are all the current recommendations still required (Yes/No)?*

Yes, the ANF considers that all the current 14 recommendations are still required.

C2 *Are changes required to any of the current Recommendations or the text following each recommendation?*

Yes.

C3 *If yes, what should be changed in the Recommendation or following text?*

C4 *What is the evidence supporting changes to the Recommendations or following text?*

Suggestions for changes to some of the current recommendations are as follows, along with supporting evidence:

Recommendation 1 Medication Advisory Committees: the ANF fully supports the continuation of MACs, and their establishment in facilities where this has not occurred. The sentence 'The MAC should include… 'needs to be amended to read:

'The MAC should include, as a minimum, a representative(s) from each of the following groups:

- Management
- General practitioner

- Registered nurse
- Nurse Practitioner, where available
- Supplying pharmacist(s) and if different, the pharmacist conducting medication reviews, and
- Resident advocate(s)'

Recommendation 2 Medication Charts: Need to include the *Interim residential care medicine administration chart* which is currently being considered by the Australian Commission on Safety and Quality in Health Care within their program on the National Inpatient Medication Chart - Medication charts and other standardisations. (See 3.1 above)

Recommendation 4 Administration of medicines: See commentary under section 2.3 regarding removal of word 'authorised' before 'enrolled nurse'. The recommendation needs to be reviewed because as it stands it encourages the use of dose administration aids (DAAs) in a manner they are not designed for, and, gives employers an option not to employ a registered nurse. Remove the footnote relating to this recommendation as, with the change to National Law in 2010, the designations indicated are no longer applicable.

Recommendation 6 Nurse-initiated medication: amend the sentence "this list should be disseminated to attending GPs' to add 'and NPs' (evidence provided under 3.2.2 above).

Recommendation 8 Alteration of oral formulations: There has been recent work undertaken by the Society of Hospital Pharmacists of Australia (SHPA) Editorial Committee on the development of a guide to medication administration in patients with swallowing difficulties or enteral feeding tubes. The new publication is called 'Don't rush to crush'. The ANF, who was involved in this work, recommends that the consultants contact the SHPA to ascertain the status of this document for inclusion of up to date information in the revised aged care guidelines.

Recommendation 8 Dose Administration Aids: The ANF contends that the purpose of DAAs is to assist a resident with self-administration of medicines. They should not be used to administer medicines to a resident, by an unqualified care worker. Medicines administered to a resident must be able to be individually recognised by the health professional undertaking the administration (including the knowledge of the positive and adverse effects of the medicine).

The word 'carer' needs to be considered for interpretation - generally the use of the term of 'carer' is in reference to a non-health professional/health worker.

Amendment needed to the sentence "Residents who are self-administering using DAAs should be assessed **by a registered nurse** to determine that they are able to safely self-administer medicines".

3.4 The format of recommendations in the current Guidelines

D1 *Is the current format of the recommendations the most appropriate (Yes/No)?*

No

D2 *If your answer to D1 is 'no' what changes to the format of the recommendations would you recommend, and why?*

The following are suggestions for changes to the format:

- Write a lead in paragraph, which includes reference to the professional specific guidelines.
- Support for the consultant's suggestion of using the format of the APAC document *Guiding principles to achieve continuity in medication management Guiding principles,* July 2005. Thus, 'recommendations' would become 'guiding principles' which conveys a stronger sense of practical use than 'recommendations'. This would correct the current problem of the recommendation heading being in italics and therefore being lost in the italics text of the recommendation which follows.

3.5 New topics which could be included in the revised Guidelines

E1 *Do you consider there are new topics that should be included in the revised Guidelines (Yes/No)?*

No

E2 *If yes, what new topic/s should be included, and why?*

A recommendation/guiding principle that emphasises the point made in the Introduction regarding the vital role of registered nurses (as qualified staff) undertaking assessment of the resident and the administration of medicines.

Also, a point in relation to the manner in which medicines are administered - that is, the registered nurse must be free from interruption, particularly when administering to large numbers of residents.

In addition, a guiding principle that medicines administration is more comprehensive than just the physical task / activity of giving the right tablets (or other forms of medicines) to the right resident. For example, assessment of condition, evaluation of clinical efficacy, and monitoring for side effects or adverse outcomes.

E3 *What issues need to be addressed in the new topic/s?*

As above.

E4 *What is the evidence supporting this new topic/s?*

The evidence is embedded in the professional competency standards for registered nurses, as originally developed under the auspice of the Australian Nursing and Midwifery Council in 2006, and adopted by the Nursing and Midwifery Board of Australia in 2010. Following the 1 July 2010 move to national registration, these standards are enforceable under the National Law 2009.

3.6 Reference materials which could be retained or developed in the revised Guidelines

F1 *What reference materials in the current Guidelines document have you found useful, and why?*

All of the existing reference material is useful to nursing staff in residential aged care facilities. Certainly the nursing specific guidelines are used extensively by nursing staff.

From a nursing perspective we would like to see a more prominent mention of the profession specific guidelines documents in the Introduction/Preamble.

F2 *What new reference materials would support use of the revised Guidelines, and why?*

Those that we have thought to be useful are mentioned in the submission, including links to state/territory drugs and controlled substances legislation.

F3 *In what format should reference materials be provided?*

The preference would be for the document to include the professional specific guidelines as for previous publications. The nursing specific guidelines will also be available on-line once the current revision is completed. There need to be very clear directions and/or links in the parent document as to where nurses can obtain the nursing guidelines. Due to the fact that some aged care facilities either don't have internet capability available to the nursing staff, or have limited availability, the ANF considers it important to have both hard copy and electronic copy of the document available.

3.6 Reference materials which could be retained or developed in the revised Guidelines

G1 *What is the essential information that should be included in the Summary?*

A plain language summary for consumers and carers could mirror the Australian Charter of Healthcare Rights[12] as developed by the Australian Commission on Safety and Quality in Healthcare. Brief explanation of such issues as: quality use of medicines, why this is important, qualifications of staff administering medicines, rights in relation to medicines.

G2 How should the Summary be structured for consumers and carers?

Clear headings, succinct information. Test language with residents, their carers, and the general public. Use of different languages.

3.8 Development of an Implementation and Education Strategy for the Guidelines and Summary

H1 *How should the Guidelines be distributed and made available to users?*

Use of different formats as mentioned previously: hard copy and on-line, and in different languages.

H2 *How should the Guidelines be distributed and made available to users?*

Could develop promotional brochures and posters, available to staff and visiting health professionals. Enlist the support of peak professional organisations to assist in disseminating information to their members and encouraging use of the guidelines.

H3 *What education activities could support the use of the Guidelines?*

Develop an on-line education module(s) which could be made available through the peak professional organisations. For example, the ANF Federal Office has an on-line continuing professional development program used extensively by members, other nurses and assistants in nursing.

H4 *How should the plain language summary be distributed and made available to users?*

Discuss with the Australian Commission on Safety and Quality in Healthcare the mechanisms employed in disseminating the Australian Charter for Healthcare Rights.

H5 *What education activities could support the use of the plain language summary?*

As for H4.

3.9 Advice to support targeted stakeholder consultations on revised and new materials

I2 *Are there any existing opportunities and processes which could be part of the local consultations (eg as a part of regular scheduled meetings of staff, committees or groups)?*

Australian College of Nurse Practitioners 2011 National Conference 6-8 October 2011.

Congress of Aboriginal and Torres Strait Islander Nurses 13th Annual Conference 21-23 September 2011, Brisbane.

Royal College of Nursing, Australia Community and Primary Healthcare Nursing Conference, 19-21 October, Hobart.

ANF Victorian Branch, could distribute invitations to their Aged Care Special Interest Group.

Coalition of National Nursing Organisations next meets in Sydney on 19 August 2011. Secretariat ANF Federal Office, Melbourne c/- Anastasia Shianis on anastasia@anf.org.au or 03 9602 8500.

I3 *Can you provide contact details for people who could assist us in organising local meetings?*

ANF State and Territory Branches as shown (should further information from the Branches come to hand this will be forwarded to the consultants):

Victoria

Mark Staaf, Professional Officer, ANF Victorian Branch, on behalf of the ANF Victorian Branch Aged Care Special Interest Group - mstaaf@anfvic.asn.au

ACT

Contact ACT ANF Branch Secretary, Ms Jenny Miragaya, and ACT ANF Branch President, Ms Athalene Rosborough, (02) 62839455 or actanf@actanf.org.au

New South Wales

NSWNA has an Annual Aged Care Nurses scheduled for 21 October 2011 - could include a session; also have an Aged Care Delegates forum prior to each Committee of Delegates meeting, next in 20 September 2011;

QACAG: Quality Aged Care Action Group - residents, carers/family, nurses working or retired (across all sectors) next meets 28 July, 29 Sept. 2011 (held at NSWNA office in Sydney)

Other organisations suggested for reaching consumers and carers are:

- Consumer Health Forum of Australia;
- National Seniors Australia;
- Senior Citizens Clubs;
- TARS - The Aged Care Rights Service;
- the Aged Care Alliance auspiced by NCOSS - Council of Social Service of New South Wales.

I4 *Can you suggest peak stakeholder organisations that may be able to assist in facilitating the local meetings?*

The ANF state and territory Branches may be able to assist with these meetings.

5. Conclusion

The ANF considers the Guidelines for medication management in residential aged care facilities to be an important document for promoting the quality use of medicines in the residential aged care sector. We therefore welcome the opportunity to provide advice to the review of the document. With changes over time since first published by the Australian Pharmaceutical Advisory Council in 1997, to policies and practices, the review is timely to ensure currency of guiding information.

The ANF looks forward to learning the outcomes of the review and to on-going participation in the revision process. As already mentioned a review is also currently being undertaken of the nursing specific guidelines: *Nursing Guidelines for the Management of Medicines in an Aged Care Setting*, written under the auspices of the ANF, Royal College of Nursing, Australia and Geriaction (the latter organisation was disbanded in 2009). We will keep the consultants informed of the progress of this review.

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