



**Aged & Community  
Services • Australia**



# **ACSA Submission**

## **FOURTH COMMUNITY PHARMACY AGREEMENT**

Submission to the Review of the Existing Supply Arrangements of PBS Medicines in Residential Aged Care Facilities and Private Hospitals - Part C

JANUARY 2009

## **Part C: Supply Arrangements of PBS Medicines in Residential Aged Care Facilities (RACF) – Additional Issues**

### **Prescription Timing**

In addition to the issues on prescription timing already raised in the discussion paper the following should be considered/noted:

- A shortage of general practitioners also impacts on the time taken for prescriptions to be written. This results in delays in residents receiving their medications, which may then impact on their overall health and wellbeing.
- The duplication that exists within the system i.e. writing up medical charts and the prescription and the significant time spent chasing up prescriptions creates barriers to establishing effective partnerships between GPs, pharmacists and aged care providers.
- Under the Aged Care Panels Initiative several Divisions of General Practice in Queensland worked with aged care providers and GPs to enable the generation of prescriptions on site. There were a couple of different initiatives/projects:
  - one where the facility had the GP software e.g. Medical Director, loaded on a computer;
  - another where the GP had a link on the facility computer which enabled them to dial in to their practice; and
  - another where the GP in their practice could prescribe and print out the prescription on site at the facility. This last option caused some issues as the GP was still required to sign the prescription as e-signature is not approved at this time. This work or the lessons learned from it, needs to be reviewed and considered.

### **Resident Transition between RACF and Hospital**

RACFs do not always receive discharge information from the hospital. Where a discharge advice is received, the medications listed often don't correlate with the medications the person was sent to hospital with and the facility and GP are left to work out which medications are to continue and which medications are now ceased.

Some hospitals have introduced discharge summaries that list both the medication on admission to hospital and the medication on discharge. This practice should be encouraged as it is very helpful to the facility, the GP and more importantly the health and well being of the resident.

### **Use of Dose Administration Aids (DAA)**

DAAs are about best practice and medication safety and ACSA believes they are an essential tool for the administration of medications in aged care. We agree there can sometimes be problems when there are different PBS medicines with different dose requirements, pack sizes and variations in the days supply provided (e.g. some packed for 28 day supply and others packed for longer). There are also problems with scripts running out at different times, and if there are repeat prescriptions, having to work out when to visit the doctor again to ensure there are enough scripts to cover the whole time frame can cause some difficulties.

Medication wastage due to prescription changes can be kept to a minimum. Some pre-packed DAAs do not require all medications within the DAA to be discarded as the pharmacist can access the pack and remove the medication/s that have changed and or add new medications. Therefore a reusable type of packaging would eliminate some of the wastage concerns.

If choice is provided about packaging systems, this has enormous implications for RACFs. If systems like WebsterCare, (where these are packed by people) are used, residents can choose name or generic brands. Choice of brand is only really a problem where the packaging is undertaken by machines. Maybe educating the community about generic versus brand name medications may help to overcome this problem.

## **Information Technology Infrastructure**

We acknowledge that IT infrastructure in many aged care facilities is limited both in access by staff to computers or the internet, and in training in how to maximise its use. Enhancements to infrastructure would need to be funded and supported.

## **Right of Choice**

ACSA acknowledges the desirability for a resident's right of choice, however, this needs to be balanced with the RACF's contractual arrangements with pharmacists.

When residents are unable to make informed decisions and are unable to manage their medication regime, they therefore cannot accept/take responsibility. The RACF is responsible for paying for any packaging, for seeing that the resident has scripts and medications and for safe medication systems under the accreditation standards. As for choice about generic medications, this could be solved by the GP ordering either generic or a certain brand on the script. This could be part of the resident medication profile sent to the pharmacist.

## **Proposed Options**

### **Option 1**

ACSA supports the use of a central document such as the resident medication chart as an order to the pharmacy for the supply of PBS medicines, the record of delivery and the administration of the medications. A list of criteria would need to be developed and agreed upon by key stakeholders as to what a medication chart would need to include to fulfill the PBS prescription requirements, legislative requirements and functional requirements for aged care staff.

### **Option 2**

ACSA supports this option.

### **Option 3**

ACSA does not support this option. The proposal that Pharmacists be given the right to obtain Authority Approvals for increased quantities and repeats from Medicare Australia raises some concern. This decision should be based upon a medical practitioner's assessment of whether such action is clinically appropriate.

## **Option 4**

Further ethical consideration is required if Pharmacists are to be collaboratively involved in prescribing and dispensing medications.

## **Option 5**

ACSA supports this option. It is important to note that currently there are not many Nurse Practitioners working in aged care. Currently Nurse Practitioners do not have prescribing rights as they are not issued with a provider number. This would have to be rectified and is unlikely to be supported by the AMA. This may be an option for the future.

## **Option 6**

ACSA supports this option.

## **Option 7**

Under the Aged Care Panels Initiative, this model was used by some Divisions of GPs and RACFs and was successful in some areas. There are various retainer models available e.g. retainers could come under Medicare payments or be paid to the facility. GPs would receive payment based on specific factors e.g. the number of residents or patients or a flat retainer fee or a sliding scale retainer fee depending on the number of residents they are responsible for in a facility. The issue of resident choice of both GP and/or Pharmacist may need to be addressed.

If you have any queries or would like to discuss this submission, please contact Mr Greg Mundy on (03) 9686 3460 or e-mail at [gmundy@agedcare.org.au](mailto:gmundy@agedcare.org.au)