

*Guidelines and Standards for the
Collaborative and Pharmacist Residential
Medication Management Review (RMMR)
Program and Associated Quality Use of
Medicines (QUM) Services*

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Guidelines and standards for pharmacists

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Guidelines for the Collaborative and Pharmacist Residential Medication Management Review (RMMR) Program and Associated Quality Use of Medicines (QUM) Services[†]

Background

Pharmacists have received remuneration from the Australian Government to deliver Medication Management Reviews in residential aged care facilities, now known as aged care homes (ACHs), since 1997. This funded service was an initiative of the Second Community Pharmacy Agreement. In the Third Community Pharmacy Agreement the model was revised to promote greater collaboration between pharmacists and general practitioners. The revised model is described in the Best Practice Framework for Collaborative Residential Medication Management Reviews (November 2002).¹

The aim of Residential Medication Management Reviews (RMMRs) is to provide a structured and collaborative review of a resident's medications to optimise the benefits from medicine use and enhance quality of life. Comprehensive information about the resident and their medicine use is collated and assessed in order to identify and meet medication-related needs and to identify, prevent and resolve medication-related problems.

PSA has developed these guidelines for pharmacists providing RMMRs and associated QUM services to ACHs. The guidelines are designed to assist pharmacists to exercise their professional judgement in individual circumstances and to promote a consistently high quality of service.

Terminology

The current accepted terminology for residential institutions is **aged care homes**. Previous terms have included residential aged care facilities (RACFs), nursing homes and hostels.

In ACHs, patients or consumers are recognised as **residents**.

An **accredited pharmacist** is a registered pharmacist who holds a valid accreditation certificate from an accreditation body – the Australian Association of Consultant Pharmacy (AACP) or the Society of Hospital Pharmacists of Australia (SHPA) – to conduct medication management reviews.

An **Approved RMMR Service Provider** is an independent registered/accredited pharmacist, or registered/accredited pharmacist who is either an approved Section 90 pharmacy proprietor or proprietor of any other business entity, who has been granted the status by Medicare Australia of being a provider of RMMR services.

A **collaborative RMMR** is characterised by the referral and participation of the GP and the accredited pharmacist in the medication review process, and is consistent with Item 903 of the Medicare Benefits Schedule.

A **pharmacist RMMR** is a RMMR service provided by an accredited pharmacist without referral by a GP.

A **RMMR Service Agreement** is an agreement between an Approved RMMR Service Provider and an ACH, for the provision of RMMR services and associated QUM services.

[†] This document replaces *Comprehensive Medication Reviews in Residential Aged Care Facilities*.
In: Australian Pharmaceutical Formulary and Handbook. 20th ed. Canberra. PSA, 2006.

¹ Medication Management Review Implementation Steering Group (MMRISG). Best practice framework for collaborative residential medication management reviews, November 2002; [cited 2006 May]. Available from: http://www.psa.org.au/media/bestpractice_framework.doc.

Guidelines and standards for pharmacists

Introduction

Australia's National Medicines Policy² recognises that each partner within the health care sector has a responsibility to participate in a cooperative endeavour to deliver better health outcomes. A central objective of the National Medicines Policy is the quality use of medicines (QUM). To achieve optimal use of medicines, all medicines should be used judiciously, appropriately, safely and efficaciously.

The National Health Strategy report *Issues in Pharmaceutical Drug Use in Australia (June 1992)* or "Macklin report" identified the high risk of medication misadventure for residents in ACHs due to their poor health status and their increased intake of medications. The report recommended a systematic approach to the development of medication review processes to improve medication use outcomes for persons in ACHs.

In a landmark study in 1995, Snowden et al. reported that levels of psychotropic drug use in Australian nursing homes were among the highest in the world, with almost 60 per cent of patients in nursing homes receiving psychotropic drugs, the major class being benzodiazepines.³ A subsequent report of the NSW Ministerial Taskforce on *Psychotropic Medication Use in Nursing Homes* examined the problem of inappropriate psychotropic medication use in nursing homes and identified strategies to ensure appropriate practice.⁴ The report recommended the institution of Medication Advisory Committees, and regular medication reviews and nurse education by consultant pharmacists.

The Australian Pharmaceutical Advisory Committee (APAC) has raised awareness of QUM in ACHs and how a multi-disciplinary approach can improve health outcomes through their *Guidelines for Medication Management in Residential Aged Care Facilities (November 2002)*.⁵

The Australian Government's quality assurance and accreditation framework⁶ for ACHs has increased demand for better medication management and pharmacists providing these services should assist nursing staff in meeting the standards.

Pharmacists have a particularly important role to play in promoting QUM in ACHs, through medication management review and QUM services, good communication with residents, collaboration with relevant health care professionals, and the development and implementation of models of best practice.

Pharmacists providing services to ACHs should focus on two broad issues:

- Resident-focused activities, such as Residential Medication Management Reviews (RMMRs); and
- Facility-focused activities, such as establishing and implementing policies and procedures for medication use and other QUM services.

RMMRs focus on ensuring that residents are receiving appropriate drug therapy and ongoing monitoring.

Facility-focused activities assist the facility with providing optimum care to all residents in the facility, as well as helping to maintain an appropriate medication use process.

The interplay of these two streams of activity are also described within the medicines management pathway, covering the cognitive and physical steps involved in the use of medicines, with a central focus on the consumer.⁷ There are nine key steps and three system-wide background processes, and as the processes and steps are interdependent, they influence each other. The pathway is applicable to the use of all medicines, independent of the setting, the health professionals involved and the funding source. This provides a framework to identify how steps are related, the potential for any errors and thus improvements in medication safety and the quality use of medicines.

Privacy and confidentiality

Each resident's right to privacy, dignity and confidentiality should be recognised and respected. An integral part of best practice in medication management in ACHs is observing residents' rights.

These rights and responsibilities are provided for under the *Aged Care Act 1997*⁸, particularly Part 4.2

2 Department of Health and Ageing. National Medicines Policy, 2000. Canberra: 1999; [cited 2006 May]. Available from: [http://www.health.gov.au/internet/wcms/publishing.nsf/content/nmp-pdf-nmp2000-cnt.htm/\\$file/nmp2000.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/content/nmp-pdf-nmp2000-cnt.htm/$file/nmp2000.pdf).

3 Snowden J, Vaughan R, Miller R, et al. Psychotropic drug use in Sydney nursing homes. *Med J Aust.* 1995;163:70-72.

4 Report of the NSW Ministerial Taskforce. Psychotropic medication use in nursing homes, May 1997.

5 Australian Pharmaceutical Advisory Council. Guidelines for medication management in residential aged care facilities, November 2002. 3rd ed.

2002; [cited 2006 May]. Available from: [http://www.health.gov.au/internet/wcms/publishing.nsf/content/nmp-pdf-resguide-cnt.htm/\\$file/resguide.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/content/nmp-pdf-resguide-cnt.htm/$file/resguide.pdf).

6 Aged Care Standards and Accreditation Agency [homepage on the Internet]. The Aged Care Standards and Accreditation Agency Ltd; c2006 [updated 2006 May 24; cited 2006 May]. Available from: <http://www.accreditation.org.au/>.

7 Stowasser DA, Allinson YM, O'Leary KM. Understanding the medicines management pathway. *J Pharm Pract Res.* 2004;34:293-296.

8 Available from: <http://www.health.gov.au/internet/wcms/publishing.nsf/content/ageing-legislat-aca1997-acaindex.htm>.

(*User Rights Principles 1997*) and are outlined in the Charter of Residents' Rights and Responsibilities in the *Residential Care Manual (April 2005)*.⁹ See Section 10.13, pages 364-5.

Consent

An accredited pharmacist must act in a way that is consistent with the National Privacy Principles in Schedule 3 to the *Privacy Act 1988*.¹⁰

Consent for an accredited pharmacist to conduct medication reviews and other QUM services should be obtained as part of the ACH's admission procedures or on an individual basis, where appropriate.

Communication

Providing RMMR and QUM services requires development of good working relationships and communication protocols with the Director of Nursing (DoN) or authorised representative, nursing staff, GPs, and supply pharmacists.

The accredited pharmacist and resident's GP should agree on a preferred method of communication on issues and information relating to the provision of medication reviews to the ACH.

Upon identification of an issue relating to documentation or supply of a medication, if the pharmacist conducting the medication review is not the supplying pharmacist, they should contact the pharmacy supplying the medication to the ACH.

Service agreements

All Commonwealth-funded ACHs are eligible to obtain access to RMMR services by entering into an RMMR Service Agreement with an Approved RMMR Service Provider.

The Service Agreement sets out the terms and conditions for RMMR and QUM services and should be read in conjunction with these guidelines.

Standards for aged care homes

*The Standards for Aged Care Facilities*¹¹ reflect the quality management and services expected of a residential aged care service. Residential aged care services are assessed against these standards to determine their suitability for accreditation by the Aged Care Standards and Accreditation Agency.

Specifically, the relevant standard (Standard 2.7 – Medication Management) states that "*Residents' medication is managed safely and correctly.*" In support of this standard, ACHs must have policies and practices to ensure that:

- There is safe administration and storage of medications;
- Incident reporting mechanisms are present, functional and acted upon;
- Medication orders are written legibly and are available to administering staff; and
- Residents' medication is regularly reviewed by appropriate health professionals.

The scope of RMMR and QUM services provided to ACHs in accordance with these Guidelines and Standards may also assist in achieving agreed outcomes in a number of other *Standards for Aged Care Facilities*, including (but not limited to):

- Continuous improvement (Standard 2.1);
- Regulatory compliance (Standard 2.2);
- Education and staff development (Standard 2.3);
- Clinical care (Standard 2.4);
- Pain management (Standard 2.8);
- Palliative care (Standard 2.9);
- Continence management (Standard 2.12);
- Behavioural management (Standard 2.13); and
- Sleep (Standard 2.17);

9 Ageing and Aged Care Division, Australian Government, Department of Health and Ageing. The residential care manual, April 2005. Canberra: 2005; [cited 2006 May]. Available from: [http://www.health.gov.au/internet/wcms/publishing.nsf/content/1cc3acd213466762ca256f19000fc9a5/\\$file/rcmfull.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/content/1cc3acd213466762ca256f19000fc9a5/$file/rcmfull.pdf).

10 Available from: http://www.privacy.gov.au/publications/privacy88_021205.pdf.

11 Department of Health and Ageing [homepage on the Internet]. Canberra: Commonwealth of Australia; c2004 [updated 1997 November 10; cited 2006 May]. Standards for aged care facilities. Available from: <http://www.health.gov.au/internet/wcms/publishing.nsf/content/ageing-standard-facility-sacfindx.htm>.

Collaborative RMMRs – Item 903

Collaborative RMMRs are available to new residents on admission to an ACH and for continuing residents on an “as required” basis, with a maximum of one RMMR for a resident in any 12 month period, except where there has been a significant change in medical condition or medication regimen requiring a new RMMR, according to the Explanatory Notes for Item 903 of the Medicare Benefit Schedule (MBS).¹² The item refers to a service where a GP works in collaboration with an accredited pharmacist to provide a RMMR.

Medicare benefits entitle a resident to one RMMR in any 12 month period, except where there have been changes in medical condition or medication regimen which may include (but are not limited to):

- Discharge from a hospital in the previous four weeks;
- Significant change to medication regimen in the past three months;
- Change in medical conditions or abilities (including falls, cognition, physical function);
- Prescription of medication with a narrow therapeutic index or requiring therapeutic monitoring;
- Presentation of symptoms suggestive of an adverse drug reaction;
- Sub-therapeutic response to treatment;
- Suspected non-compliance or problems with managing medication-related therapeutic devices; or
- Risk of inability to continue managing own medications (e.g. due to changes in dexterity, confusion or impaired sight).

Approved RMMR Service Providers should discuss procedures for initiation and implementation of collaborative RMMRs with individual GPs, ACHs and/or through Medication Advisory Committees (MACs), where appropriate.

Comprehensive Medical Assessment

Comprehensive Medical Assessments (CMAs) are available to new and existing residents in ACHs, according to the Explanatory Notes for Item 712 of the MBS.¹³ A CMA involves a GP taking a detailed relevant medical history, conducting a comprehensive medical examination, developing a list of diagnoses or problems, and providing a written summary of the outcomes of the CMA for the resident’s records.

CMAs complement other services such as collaborative RMMRs and Enhanced Primary Care (EPC) services for contribution to a multidisciplinary care plan and for case conferencing. A copy of the written summary of the outcomes of the CMA should be provided to the ACH.

The written summary of the outcomes of a CMA can assist an accredited pharmacist in providing medication management review services for the resident. Approved RMMR Service Providers should discuss procedures for integration of CMAs with collaborative RMMRs with individual GPs and/or through MACs, where appropriate.

RMMR process

A RMMR is a comprehensive medication review that is resident-focused involving the systematic evaluation of the resident’s complete medication regimen and management of that medication in the context of other clinical information and the resident’s health status. It involves identification of risk, the development and maintenance by the pharmacist of a resident profile, data collection, identification of medication-related problems, formulation of recommendations, documentation and reporting, and follow-up and monitoring. It is conducted in collaboration with other members of the health care team. The resident should be consulted if appropriate. A RMMR aims to identify, prevent and resolve actual or potential medication-related problems, optimise pharmacotherapy and ensure positive health care outcomes.

The goal of a RMMR is to improve therapeutic outcomes for the resident and to ensure quality use of medicines; that is, the judicious, appropriate, safe and effective use of medicines by:

- Identifying medication-related problems;
- Minimising adverse drug effects and drug interactions;
- Working with prescribers with drug therapy selection, dosing and monitoring;
- Improving quality of life;
- Maintenance or improvement of functional status;
- Encouraging enhanced collaboration between pharmacists and GPs and other members of the health care team; and
- Reducing health care costs.

The accredited pharmacist should adopt a systematic approach to the RMMR process. A RMMR should be

12 Available from: <http://www.health.gov.au/internet/wcms/publishing.nsf/content/health-epc-dmmrqa.htm>.

13 Available from: http://www.health.gov.au/internet/wcms/publishing.nsf/content/health-medicare-health_pro-gp-cmarach.htm.

performed in an organised fashion using a systematic process to gather data, identify potential and actual medication-related problems, consult and decide upon the most appropriate options to remedy the situation, and document findings and recommendations.

Recent documents produced by the Australian Pharmaceutical Advisory Council – *Guiding principles to achieve continuity in medication management*¹⁴ – and the Society of Hospital Pharmacists of Australia – *Standards of practice for clinical pharmacy* – are useful resources that also support a systematic approach for medication management review that is applicable to RMMRs.

a) Identification of risk

A RMMR may be triggered by the accredited pharmacist, supply pharmacist, nursing staff, GP, other members of the health care team, the resident or a carer. A collaborative RMMR must include a referral by a GP, according to the MBS for Item 903. Preferably, the GP's referral should identify any potential medication-related problems or clinically relevant issues.

The following risk factors are known to predispose people to medication-related adverse events and priority should be given to residents in whom any of the following are deemed clinically relevant:

- Taking five or more regular medications;
- Taking more than twelve doses of medication per day;
- Suffering three or more medical conditions;
- Admission to a facility or hospital in the last four weeks;
- Significant changes to medication regimen in the last three months;
- Taking medication with a narrow therapeutic index or requiring therapeutic monitoring;
- Symptoms suggestive of an adverse drug reaction;
- Sub-therapeutic response to treatment;
- Suspected non-compliance or problems with managing medication-related therapeutic devices;
- Self-managing own medications and are at risk due to language difficulties, dexterity problems, impaired sight or cognitive difficulties; or
- Increasing frailty.

b) Resident profile

A resident profile should be established for each resident undergoing a RMMR and updated prior to conducting subsequent reviews to enable monitoring of clinical progress. The resident profile should include relevant personal, social and health information which provides a context in identifying and assessing medication-related issues and problems. This resident profile serves as the accredited pharmacist's record to support recommendations to the general practitioner.

The type and range of information which may be gathered to develop the resident profile may include:

Demographic/personal information

- Full name of resident;
- Medicare/RPBS card number;
- Bed, room or wing number of resident;
- Date of birth, gender, weight (including recent changes) and height of resident.

Relevant social history

Factors that may influence health status, therapeutic outcomes and willingness or ability to manage medications include:

- (Previous) occupation, lifestyle and cultural factors;
- Family and other social support systems;
- Attitudes to health, illness and treatments that influence the resident's understanding, expectations, concerns or preferences.

Medical history

- Past medical history;
- Past surgical history;
- Current condition(s) and associated clinical signs and symptoms;
- Laboratory test results;
- Allergies and previous adverse drug reactions.

Medication history

A complete up-to-date medication profile should be developed for each resident by collating information from the medication chart, admission summary, hospital discharge summaries and other sources, such as the

14 Available from: <http://www.health.gov.au/internet/wcms/publishing.nsf/content/nmp-guiding>.

dispensing history from the supply pharmacy. This process assesses the completeness and accuracy of medication records and highlights issues related to the storage, supply and administration of medications.

The medication profile should include:

- Current medications (including prescription and non-prescription, over-the-counter and complementary medicines);
- Dose, strength, dose form, directions, route and duration;
- Nurse-initiated medications;
- When necessary or “prn” medications and the frequency of their use;
- Once only or “stat” medications;
- Short term medications; and
- Administration instructions.

Resident assessment

For accredited pharmacists to play an optimal role in addressing medication-related problems, assessment of the resident should accompany the medication management review process in collaboration with GPs, nursing staff and supply pharmacist, where appropriate. This assessment is the application of clinical interviewing, observational and physical assessment skills to obtain and integrate information about the resident, clinical conditions, and currently prescribed medications.¹⁵ Medications can affect cognition, mood, gait, and movement, which in turn may affect activities of daily living. Interviewing and observing the resident to assess aspects of cognition, affective state, physical condition, and social factors may assist in the identification and resolution of medication-related problems.

c) Data collection

A medication chart review is an integral part of a RMMR; however, additional information sources should be used to collate comprehensive information about the resident, including:

- Admission records;
- Prescriber(s) progress notes;
- Comprehensive medical assessment (CMA);
- Nursing progress notes;

- Nursing care plans;
- Medication dispensing history;
- Hospital discharge summaries; and
- Laboratory test results.

This information should be documented in the resident profile and be evaluated in the context of the resident’s clinical status to identify actual, suspected or potential medication-related problems.

Accredited pharmacists conducting reviews should confirm the preferred means by which they may access required information with appropriate personnel within the facility and/or through the MAC (where appropriate).

d) Identification of medication-related problems

A medication-related problem can be described as any undesirable event experienced by the resident that is thought to involve drug therapy, and that actually or potentially interferes with a desired patient outcome.¹⁶ Eight types of medication-related problems have been identified:¹⁷

- *Medication use without indication* – the resident is taking a medication for no medically valid indication.
- *Untreated indication* – the resident has a medical problem that requires drug therapy but is not receiving a drug for that indication.
- *Improper drug selection* – the resident has a drug indication but is taking the wrong drug, or is taking a drug that is not the most appropriate for the special needs of the resident.
- *Sub-therapeutic dosage* – the resident has a medical problem that is being treated with too little of the correct medication.
- *Overdosage* – the resident has a medical problem that is being treated with too much of the correct medication.
- *Adverse drug reactions* – the resident has a medical problem that is the result of an adverse drug reaction or adverse effect.
- *Drug interactions* – the resident has a medical problem that is the result of a drug-drug, drug-food, or drug-laboratory test interaction.
- *Failure to receive medication* – the resident has a medical problem but is not receiving the prescribed medication.

15 Gardner ME. A patient assessment approach to enhance the drug regimen review process. *Consult Pharm.* 1999;9:982-96; [cited 2006 May]. Available from: http://www.ascp.com/publications/tcp/1999/sep/r_r.shtml.

16 Cipolle RJ, Strand LM, Morley PC. *Pharmaceutical care practice*. New York: McGraw Hill; 1998.

17 Strand LM, Morley PC, Cipolle RJ, Ramsey R, Lamsam GD. Drug-related problems: their structure and function. *DICP, The Ann Pharmacotherapy.* 1990;24:1093-7.

Other tools to assist in identification of medication-related problems include the Medication Appropriateness Index¹⁸ and Beers explicit criteria.¹⁹

Once identified, the clinical relevance of medication-related problems in the context of the resident's clinical status should be assessed and prioritised.

e) Optimisation of medication

Accredited pharmacists should also consider the efficacy of the resident's medications in the context of the clinical status of the resident. A review of the appropriate options should be conducted and prioritised for the consideration of the GP.

f) Formulation of recommendations

Accredited pharmacists should formulate recommendations for resolution or prevention of medication-related problems identified. These recommendations may fall into three categories:

- Medication changes;
- Education and adherence;
- Monitoring.

Recommendations should address identified medication-related problems, and include a summary of actual or potential impact on the resident and options for resolution or prevention.

Changes to the resident's medication regimen will be determined by the GP in consultation with the ACH and pharmacist, after consideration of the pharmacist's report in the context of the clinical status and needs of the resident.

Accredited pharmacists should also provide medication information or advice to nursing staff and carers, including that required to safely and effectively administer medication. The information is designed to address resident or staff concerns, reduce confusion, achieve safe and appropriate use of medication and adherence with the medication regimen in order to optimise therapeutic outcomes. Information and advice regarding therapeutic devices, storage, preparation and administration may also be included. Information should be provided both verbally and in written form, including Consumer Medicines Information (CMI).

g) Documentation and reporting

The accredited pharmacist should document that a RMMR has been conducted in the resident's medication chart and progress notes.

A record should be kept of all problems identified, recommendations, interventions and follow-up activities, the date and time they were made or undertaken and whether they were in verbal or written form. The names of medical practitioners, pharmacy staff and nursing staff with whom contact was made and the dates of contacts should also be documented.

The accredited pharmacist should provide a written report for consideration by the GP outlining the actual or potential medication-related issues and recommendations. The report should be communicated in a way agreed with the GP and the ACH.

A written copy of the RMMR report should also record actions agreed upon by the GP resulting from the accredited pharmacist's interventions and recommendations when they are known at the time of reporting. In the case of a collaborative RMMR (Item 903) a copy of the final agreed medication management plan should be included in the resident's care notes.

All documentation should be stored in a safe, secure environment.

h) Follow-up and monitoring

The accredited pharmacist should follow-up and document outcomes at subsequent visits and provide additional comments and recommendations where appropriate.

Accredited pharmacists have a critical role in the effective monitoring of the resident. The accredited pharmacist may recommend monitoring parameters for the resident, then review results of monitoring to help evaluate the outcomes of therapy and recommend any needed changes.

i) Frequency of service

Residents should have access to a RMMR upon admission, once every 12 months thereafter and when deemed clinically appropriate.

Generally an initial RMMR should be conducted as soon as appropriate after admission to the ACH. It is recommended that this initial medication review is

18 Samsa GP, Hanlon JT, Schmadre KE, et al. A summated score for the medication appropriateness index: development and assessment of clinimetric properties including content validity. *J Clin Epidemiol.* 1994;47(8):891-6.

19 Fick DM, Cooper JW, Wade WE, et al. Updating the Beers criteria for potentially inappropriate medication use in older adults. *Arch Intern Med.* 2003;163:2716-2724.

conducted as a *collaborative* RMMR as part of the formal admission process of the ACH. This process is likely to include a CMA and the development of a nursing care plan.

Collaborative RMMRs may be conducted once in any 12 month period, except where there has been a significant change in medical condition or medication regimen, according to the Explanatory Notes for Item 903 of the MBS.

Pharmacist RMMRs may be conducted upon admission, once every twelve months and when clinically relevant. An “as required” RMMR may be initiated at any time if in the opinion of the nursing staff, pharmacist, other health professionals, resident or carer, it is indicated. For example, this may include a significant change in the clinical status of the resident or the development of signs and symptoms of drug toxicity.

A flowchart of the RMMR process is set out at Appendix A.

QUM services

A range of facility-focused activities, such as establishing policies and procedures for medication use and other QUM services should be provided to the ACH. Facility-focused activities assist the facility with providing optimal care to all residents, as well as helping to maintain an appropriate medication use process.

The provider of QUM services may be different to the RMMR Service Provider. In instances where the provider of QUM services and the RMMR Service Provider are different, it is the responsibility of the RMMR Service Provider to sub-contract the QUM services. It is the responsibility of the ACH and the RMMR Service Provider to develop and agree upon the specified QUM activities that best cater for the individual needs of the ACH.

The following are examples of QUM services. A selection of these QUM services should be provided to the ACH in accordance with the RMMR Service Agreement:

a) Medication advisory activities

- Participate in drug usage evaluation (DUE);
- Advise members of the health care team on a range of issues, including storage, administration, dose forms, compatibilities, therapeutic and adverse effects and compliance.
- Participate in MACs;

- Assist in the development of nurse-initiated medication lists;
- Participate in policy and procedure development activities;
- Assist in the development of policies and procedures to address medication management concerns e.g. sleep, bowel or pain management, and infection control.

b) Education

- Provide in-service sessions for nursing staff and carers or residents on medication therapy, disease state management or prescribing trend issues;
- Provide drug information for medical practitioners and ACH staff, including provision of newsletters.

c) Continuous improvement

- Assist the facility to meet and maintain medication management accreditation standards and to comply with regulatory requirements;
- Assess competency of residents to self-administer medications;
- Assess medication storage requirements, monitoring and standards, including storage and labelling, expired stock, security of medication storage areas and safe disposal of unwanted medications;
- Conduct medication administration audits and surveys on medication errors, altered dosage forms and psychotropic drug use;
- Assist with the development of, and report on, quality indicators and other quality measures.

Medication Advisory Committee (MAC)

The MAC is an integral component of the continuous quality improvement and safety framework for QUM. MACs may be convened on an individual, group or regional basis. The role of a MAC is to advise on any matter relating to medication use with the view to optimising health outcomes for the resident through QUM.

Pharmacists providing services to ACHs should be represented on the MAC. This includes the accredited pharmacist conducting medication management reviews and the supply pharmacist, if different.

Further information, terms of reference and scope of activities are detailed in the APAC *Guidelines for Medication Management in Residential Aged Care Facilities (November 2002)*.²⁰

20 Australian Pharmaceutical Advisory Council. Guidelines for medication management in residential aged care facilities, 2002. 3rd ed.;

[cited 2006 May]. Available from: [http://www.health.gov.au/internet/wcms/publishing.nsf/content/nmp-pdf-resguide-cnt.htm/\\$file/resguide.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/content/nmp-pdf-resguide-cnt.htm/$file/resguide.pdf).

Drug usage evaluation (DUE)

A DUE is a quality assurance/management activity for drug therapy to promote rational and economical drug use and to improve therapy outcomes. The aim of the DUE cycle is to improve resident care by improving drug use. Success can be measured by comparing practice with best practice standards and guidelines, or alternatively by measurement of patient outcomes or resource use.

Drug usage evaluation has two main phases operating in an iterative cycle. The first phase is investigative: measuring and defining drug use, identifying drug use problems and measuring the impact of interventions. The second phase is interventional: problem solving, consensus building and implementation of activity directed at improving drug use.

Participation in a DUE should be discussed and co-ordinated through the MAC or other quality assurance committees. If drug use is found to be inappropriate, policies and guidelines should be developed and implemented through the MAC or other quality assurance committees. Drug usage evaluations also meet components as a continuous improvement activity of the *Standards for Aged Care Facilities* issued by the Aged Care Standards and Accreditation Agency.

A flowchart of the QUM process is set out at Appendix B.

Further resources

- American Society of Consultant Pharmacists. Consultant pharmacist handbook: a guide for consulting to nursing facilities, 2004. 1st ed.
- Australian Pharmaceutical Advisory Council. Guiding principles to achieve continuity in medication management. Canberra: Commonwealth of Australia; 2005. Available from: <http://www.health.gov.au/internet/wcms/publishing.nsf/content/nmp-guiding>.
 - Guiding principle 4 – accurate medication history;
 - Guiding principle 5 – assessment of current medication management;
 - Guiding principle 6 – medication action plan;
 - Guiding principle 7 – supply of medicines information to consumers.
- Dartnell JGA. Understanding, influencing and evaluating drug use. North Melbourne: Therapeutic Guidelines Limited; 2001. An order form may be obtained from: <https://www.tg.com.au/order/order1.php>.
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- The Royal Australian College of General Practitioners – ‘Silver Book’ National Taskforce. Medical care of older persons in residential aged care facilities, 2005. 4th ed. Available from: <http://www.racgp.org.au/silverbook/foreword.asp>.
- Sanburg AL, McGuire TM, Lee T. Stepping out of constipation - an educational campaign. Aust J Hosp Pharm. 1996;26:351-5.
- SHPA standards of practice for clinical pharmacy, August 2004. J Pharm Pract Res. 2005;35(2):122-46.
 - Accurate medication history (Appendix A);
 - Assessment of current medication management (Appendix B);
 - Clinical review (Appendix C);
 - Decision to prescribe a medicine (Appendix D);
 - Therapeutic drug monitoring (Appendix E);
 - Participation in multidisciplinary ward rounds and meetings (Appendix F);
 - Provision of medicines information to health professionals (Appendix G);
 - Provision of medicines information to patients (Appendix H);
 - Information for ongoing care (Appendix I);
 - Adverse drug reaction management (Appendix J).
- SHPA standards of practice for drug usage evaluation in Australian hospitals, May 2004. J Pharm Pract Res. 2004;34(3):220-3.
- SHPA guidelines for self-administration of medication in hospitals and residential care facilities, August 2002. J Pharm Pract Res. 2002;32(4):324-5.

Note: Copies of articles from the *Journal of Pharmacy Practice and Research* and *The Australian Journal of Hospital Pharmacy* can be ordered from the National Library of Australia at <http://www.nla.gov.au/copiesdirect/>.

Standard for Residential Medication Management Review

(Also known as Comprehensive Medication Review [CMR])

Standard: The pharmacist systematically reviews and evaluates the consumer's medication treatment regimen and takes appropriate action to optimise therapeutic outcomes and ensure their access to regular reviews.

Scope of this standard

- Legislative requirements are not addressed in this standard. It is assumed that pharmacists will comply with required State/Territory legislation in the provision of this service.
- This standard applies to the comprehensive, systematic review and evaluation of a consumer's treatment regimen with follow-up, as required, with the consumer and their health care providers. The service may be undertaken for the benefit of consumers who do not meet the criteria for a Home Medicines Review (HMR), such as those in Residential Care Facilities.
- Where an HMR is provided, pharmacists are advised to refer to the *HMR standard*.
- The term 'medication review' encompasses a continuum of processes in various formats and complexities, ranging from opportunistic discussion to a more comprehensive and proactive approach to reviewing the consumer's medication treatment regimen. The terminology used to describe this service has evolved to differentiate it from the simple medicines review carried out at the time a medicine is dispensed without the benefit of specific clinical information.



- Pharmacists are reminded that this standard should be applied in conjunction with the Fundamental Pharmacy Practice standard. Refer also to the *Counselling and Health Promotion standards where appropriate*.

Criterion 1 The pharmacist is experienced in, and has training, to undertake medication reviews.

- | | | | |
|------------------|----------|--|--------------------------|
| Indicator | 1 | Completes specialised training for the provision of CMR. | <input type="checkbox"/> |
| | 2 | Maintains access to appropriate support services. | <input type="checkbox"/> |

Notes

Suitable support services include clinical practice support, clinical mentoring or services such as drug information services. Pharmacists should contact their state PSA branch for details of available local services.

Criterion 2 The pharmacist uses formal documentation to record the CMR.

- | | | | |
|------------------|----------|--|--------------------------|
| Indicator | 1 | Maintains a system of documenting issues identified in the CMR and actions taken arising from the review. | <input type="checkbox"/> |
| | 2 | Ensures documentation is appropriately designed and utilised to record all information required in the provision of CMR. | <input type="checkbox"/> |
| | 3 | Ensures documentation is stored securely during all stages of the CMR. | <input type="checkbox"/> |

Notes

Standardised documentation assists in the recording of important events and outcomes arising from the CMR. It facilitates the systematic recording of the critical elements of the CMR, and enables easy retrieval of information when follow-up is required. The pharmacist should initiate and maintain appropriate documentation for each consumer whose medication has been reviewed. Proformas or suitable electronic products are available to assist pharmacists with documentation.

Criterion 3 The pharmacist provides consumers with access to regular CMR.

- | | | | |
|------------------|----------|--|--------------------------|
| Indicator | 1 | The pharmacist records the medication review dates on the CMR documentation. | <input type="checkbox"/> |
| | 2 | The pharmacist uses an alert system for follow-up reviews. | <input type="checkbox"/> |
| | 3 | The consumer is informed of the follow-up opportunities. | <input type="checkbox"/> |

Notes

Medication management is optimised when the pharmacist provides a regular follow-up CMR. It is recommended that the pharmacist and prescriber co-operate in undertaking a CMR for consenting consumers who meet the criteria for risk of drug misadventure.

Criterion 4 CMR is undertaken with the consent of the consumer (or other legally recognised authority/individual where the consumer is unable to consent).

- | | | | |
|------------------|----------|---|--------------------------|
| Indicator | 1 | The pharmacist obtains written consent as appropriate to the setting. | <input type="checkbox"/> |
|------------------|----------|---|--------------------------|

Notes

The consent form should also address the need to exchange information with other members of the health care team.

Criterion 5 A medication profile is established and maintained with consumer involvement.

- | | | | |
|------------------|----------|---|--------------------------|
| Indicator | 1 | Conducts and documents a medication history interview with the consumer. | <input type="checkbox"/> |
| | 2 | Maintains CMR documentation, including a consumer medication profile, for each consumer whose medicines have been reviewed. | <input type="checkbox"/> |

Notes

A profile should be established for each consumer undergoing CMR. The type and range of information gathered to develop a profile are described in the guidelines. The consumer medicine profile should be updated before subsequent reviews are conducted so that it can be used to monitor therapeutic progress.

Criterion 6 Accurate documentation is initiated and maintained about the pharmacist's follow-up actions during the CMR.

- | | | | |
|-----------|---|--|--------------------------|
| Indicator | 1 | Records the medicines-related issues identified during the CMR. | <input type="checkbox"/> |
| | 2 | Documentation allows for recording of contact with other health professionals. | <input type="checkbox"/> |

Notes

Accurate documentation must be initiated and maintained for all stages of the CMR. In particular, a record should be kept of all recommendations, interventions and follow-up activities, the date and time they were made, and whether they were oral or written. The documentation must be presented in a manner that allows colleagues to identify the date on which the action was taken, the action that was taken and the person who took the action.

Criterion 7 Current or potential therapeutic problems and treatment options identified from the CMR are reported to the medical practitioner or other health professional, and appropriately documented.

- | | | | |
|-----------|---|---|--------------------------|
| Indicator | 1 | Considers the recipient's preferred method of communication when communicating with other health professionals. | <input type="checkbox"/> |
| | 2 | Documentation includes consideration of potential therapeutic problems, treatment options, recommendations and actions. | <input type="checkbox"/> |
| | 3 | Documents the date and time of the contact, and the name of the prescriber/health professional with whom the therapeutic problems and treatment options were discussed. | <input type="checkbox"/> |

Notes

The pharmacist must ensure that documentation systems and procedures exist for follow-up of all interventions, recommendations and advice. The outcomes should be recorded and further follow-up considered if necessary.

It is envisaged that the pharmacist will provide consumers with advice and information and communicate with their relevant health care professionals, both while reviewing consumers' medicines and, as appropriate, after the review is completed.

Criterion 8 The outcomes of the pharmacist's recommendations arising from the CMR are accurately and appropriately documented.

- | | | | |
|-----------|---|--|--------------------------|
| Indicator | 1 | Records the date and actions taken by the prescriber and/or registered nurse as a result of the pharmacist's recommendations and/or interventions. | <input type="checkbox"/> |
| | 2 | Records the outcomes of discussion with the prescriber regarding therapeutic problems and treatment options. | <input type="checkbox"/> |

Notes

Communication with the medical practitioner should occur face-to-face or, where this is not possible, via a mutually agreed process. The medical practitioner will determine any changes to the consumer's treatment regimen after considering the information in the pharmacist's report, and the consumer's clinical status and needs. Actions arising from the CMR could also include provision of a medication delivery device or provision of medication information to enhance the consumer's understanding.

Guidelines and standards for pharmacists

Declaration

(Self-assessment and declaration to be completed by all pharmacists providing this service)

Reasons why any indicators are marked 'not applicable'

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Action to be undertaken for each indicator currently not met

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.....
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.....

I have completed this assessment in a fair and ethical manner, and fulfil the marked indicators in the provision of this service.

Signed Date

Information resources

- 1 Pharmaceutical Society of Australia. The Provision of Pharmacy Services to Residential Aged Care Facilities. In: Australian Pharmaceutical Formulary and Handbook. 20th ed. Canberra. PSA, 2006.

Standard for Services to Residential Care Facilities

Standard: The pharmacist provides a comprehensive medication management service to residential care facilities, which includes the accurate and timely provision of medicines and information to optimise therapeutic outcomes, and review of the quality and safety of facility systems with respect to medicines.

Scope of this standard

- Legislative requirements are not addressed in this standard. It is assumed that pharmacists will comply with required Commonwealth/State/Territory legislation in the provision of this service.
- This standard applies to the issue, distribution and storage of medicines as well as medication management services to residential care facilities. It is expected that the individual elements of service provision and roles are clearly defined in a contractual agreement between the relevant pharmacists and the facility.
- For the purpose of this standard:
 - the 'facility' refers to the 'residential care facility', which includes nursing homes, retirement facilities, hostels and supported residential services (previously known as special accommodation homes);
 - 'medication profile' refers to the pharmacist's accurate complete and comprehensive record of medicines for a particular resident;
 - 'resident notes' refer to the facility's progress notes for a particular resident, where available;
 - 'carer' is anyone responsible for, or taking part in, the provision of care for another person (including parents, guardians or care workers). A care worker is a paid worker with a title such as carer, aboriginal health worker, assistant in nursing, personal care assistant, HACC (Home and Community Care) worker;
 - 'medication chart' refers to the official document used to order, supply and administer medicines; and
 - 'pharmacist' may refer to more than the one pharmacist providing more than one service, that is, a supply pharmacist or the review pharmacist. In some instances the same individual pharmacist may provide more than one service.
- Pharmacists are reminded that this standard is to be applied in conjunction with the Fundamental Pharmacy Practice standard. Refer also to other standards applicable to the specific services being provided, such as the *Counselling, Dispensing and Dose Administration Aids Service* standards where appropriate.

Guidelines and standards for pharmacists

Criterion 1 The pharmacist checks the medicines of all residents as soon as practicable after admission, to ensure consistency with the medication treatment regimen.

- | | | | |
|-----------|---|--|--------------------------|
| Indicator | 1 | Requests routine notification when a resident is admitted. | <input type="checkbox"/> |
| | 2 | Reviews the medicines and reconciles the medication profile when a resident has been admitted. | <input type="checkbox"/> |
| | 3 | Maintains a current medication profile for all residents. | <input type="checkbox"/> |

Notes

Pharmacists should be aware that it is important to review the medication profile on admission and re-admission after extended leave or hospitalisation.

The comprehensive and accurate review of medicines and devices used includes checking the dating of the current medication list from the general practitioner or the discharge medication list, and cross checking with the medication profile. Medication trolleys and the residents' bedside drawers should be checked during the review process.

The medication profile may refer to a document that is verified by the pharmacist, or a copy of the actual medication order. Ultimately, the original medication chart must be sighted and verified.

Criterion 2 The pharmacist maintains appropriate systems for the supply of medicines to the facility.

- | | | | |
|-----------|---|---|--------------------------|
| Indicator | 1 | Dispenses medicines for the resident in response to a received prescription. | <input type="checkbox"/> |
| | 2 | Supplies medicines for stock in response to a requisition from the facility. | <input type="checkbox"/> |
| | 3 | Ensures a system is in place to communicate all changes in medication regimens to the supply pharmacy in a timely manner. | <input type="checkbox"/> |

Notes

The pharmacist or a dispensing technician working under the supervision of a pharmacist and adhering to commonwealth/state/territory legislation provides the medicines in accordance with the contractual arrangements to the residential care facility.

Criterion 3 The pharmacist ensures that medicines are delivered to the facility in a timely manner.

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|-----------|---|--|--------------------------|
| Indicator | 1 | Maintains a regular schedule for delivering medicines to the facility. | <input type="checkbox"/> |
| | 2 | Provides an emergency delivery service to the facility to cover extraordinary circumstances. | <input type="checkbox"/> |
| | 3 | Ensures that the medicines are delivered to an authorised person. | <input type="checkbox"/> |

Notes

Both the pharmacy and the facility should agree on service delivery arrangements, in consultation with the health care professional. Procedures for a delivery system that documents the receipt procedure appropriately should also be considered. Controlled drugs and prescription medicines should be delivered to a registered nurse or authorised delegate, as prescribed by legislation. Regular and emergency deliveries must be accommodated to ensure medication treatment of residents is not compromised.

Guidelines and standards for pharmacists

Criterion 4 The pharmacist liaises with the facility to ensure that medicines are stored according to legislative and manufacturers' storage requirements.

- | | | | |
|-----------|---|---|--------------------------|
| Indicator | 1 | Advises the facility of the need to have a documented procedure on the safe and secure storage of medicines. | <input type="checkbox"/> |
| | 2 | Provides information on special storage conditions (eg refrigeration) on the label of dispensed medicines and on outer packaging or container of stock medicines and Dose Administration Aids (DAAs). | <input type="checkbox"/> |
| | 3 | Liaises with the facility to ensure that the medicines held in the facility are checked at regular intervals to make sure they are stored and discarded appropriately. | <input type="checkbox"/> |

Notes

The pharmacist should provide advice about appropriate environmental storage conditions for all pharmaceuticals kept in the facility. Medicines should be kept in secure locations so that they are not accessible to unauthorised persons. Storage of all scheduled medicines should be monitored. The parameters of access to the facility by pharmacy staff should be defined in the contractual arrangements. Where it is not possible to have pharmacy staff on site, the pharmacist should ensure that the facility is aware of the requirements for storing medicines. Where this is not the pharmacist's direct contractual responsibility, it is recommended that the Medication Advisory Committee be advised of the requirements.

Criterion 5 The pharmacist facilitates an appropriate stock control system.

- | | | | |
|-----------|---|---|--------------------------|
| Indicator | 1 | Facilitates a system to determine the range of commonly used medicines that would be required as stock. | <input type="checkbox"/> |
| | 2 | Facilitates the regular review of medicine usage to ascertain the appropriateness of the stock held at the facility. | <input type="checkbox"/> |
| | 3 | Checks regularly that sufficient medicines are available and excess stock is not accumulating. | <input type="checkbox"/> |
| | 4 | Provides education for facility staff on the correct procedure for medicine storage and rotation. | <input type="checkbox"/> |
| | 5 | Liaises with the facility to assist in the development of systems to monitor expired medicines and other medicines considered unsuitable for use, and where necessary, those medicines are removed with consumer consent. | <input type="checkbox"/> |

Notes

Some indicators of this criterion may be performed by either pharmacy or facility staff, depending on the size and type of facility, and the contractual obligations of the pharmacy.

Stock control systems should apply to all medicines and devices, and should apply to all storage locations such as bedside lockers, medication trolleys and refrigerators.

Criterion 6 An accredited pharmacist conducts a comprehensive medication review for all residents at regular intervals and maintains appropriate records.

- | | | | |
|-----------|---|---|--------------------------|
| Indicator | 1 | Ensures all relevant sources of information are used in the medication review. | <input type="checkbox"/> |
| | 2 | Maintains a system to prioritise high-risk residents and ensure timely reviews. | <input type="checkbox"/> |
| | 3 | Ensures there is an agreed means of timely communication with prescribers. | <input type="checkbox"/> |
| | 4 | Ensures active communication with the supply pharmacist in a timely manner. | <input type="checkbox"/> |
| | 5 | Monitors any interventions recommended by the review at the next visit to assess the outcome and take further action, if necessary. | <input type="checkbox"/> |

Notes

A comprehensive medication review is conducted in accordance with the *Comprehensive Medication Review* standard. The accredited pharmacist should document the procedure for selection of residents for review according to contractual obligations and professional judgement. The review will focus primarily on a medication order review of the type referred to in the relevant section of the professional guidelines.

The medication record should have the following information: resident's name, age, weight, sex, pharmaceutical benefits or repatriation concession or entitlement number, and medical practitioner's name; medical conditions; currently prescribed medicines and non-prescription medicines used; and drug allergies.

It is important that actions the pharmacist takes in relation to the resident's medication treatment regimen are recorded in the resident notes held by the facility. This will allow other members of the health care team to be aware of these actions. The pharmacist should also make sure that their resident medication profile contains this information to ensure continuity in pharmacy services.

The reviewing pharmacist should consult the supply pharmacist and all attending medical practitioners, and consider the nursing staff notes.

Criterion 7 The pharmacist reports issues relating to medication administration to appropriate nursing staff.

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|------------------|----------|--|--------------------------|
| Indicator | 1 | Documents the date and time of the contact and the name(s) of the nursing staff with whom issues about medication administration were discussed. | <input type="checkbox"/> |
| | 2 | Records the issues discussed with nursing staff in their medication review documentation. | <input type="checkbox"/> |

Notes

The pharmacist should have a documented procedure for reporting medication-related issues to the resident's medical practitioner and other members of the health care team.

Criterion 8 The pharmacist maintains a system that identifies, monitors and documents events such as Adverse Drug Events (ADE), Adverse Drug Reactions (ADR), and Therapeutic Drug Monitoring (TDM) where requested.

- | | | | |
|------------------|----------|---|--------------------------|
| Indicator | 1 | Identifies residents whose medication profile indicates a need for TDM. | <input type="checkbox"/> |
| | 2 | Assists in the interpretation of drug assay results and provides recommendations for changes to drug therapy as required. | <input type="checkbox"/> |
| | 3 | Maintains records of all TDM interventions in the resident notes (where available) and the resident medication profile. | <input type="checkbox"/> |
| | 4 | Facilitates a system for reporting ADEs and ADRs. | <input type="checkbox"/> |
| | 5 | Takes reasonable steps to identify suspected ADEs and ADRs when reviewing medications and notifies the prescriber where these are clinically significant. | <input type="checkbox"/> |
| | 6 | Facilitates a system to prevent the ADR medicine being re-administered. | <input type="checkbox"/> |

Notes

Therapeutic Drug Monitoring (TDM) involves monitoring the concentration of drugs in the body, and using the information to adjust drug dosage where appropriate. The pharmacist should be able to recognise a need for drug therapy monitoring, recommend monitoring where appropriate, and be available to interpret the result and provide recommendations for alternations in therapy.

Pharmacists should refer the APAC guidelines for information on the role of the Medication Advisory Committee (MAC).

An Adverse Drug Event (ADE) has been defined by the Australian Council for Safety and Quality in Health Care as an adverse event where a medicine is implicated as a causal factor. An ADE encompasses both the harm from the intrinsic

Guidelines and standards for pharmacists

nature of the medicine (eg an adverse drug reaction) as well as the harm that results from medication errors or system failures associated with the manufacture, distribution or use of medicines.

The World Health Organization defines an Adverse Drug Reaction (ADR) as: “any response to a drug which is noxious and unintended, and which occurs at doses normally used in man for prophylaxis, diagnosis or therapy of disease, or for the modification of physiological function”. Details on ADR management can be found in the *SHPA Standards of Practice for Clinical Pharmacy*.

‘Blue card’ report forms are available from: The Secretary, Adverse Drug Reactions Advisory Committee, PO Box 100, WODEN, ACT 2606, Telephone (02) 6232 8380. Reports may also be submitted via the Internet at <https://www.tgasime.health.gov.au>.

Criterion 9 The pharmacist provides information and education on medicines that adequately meets the needs of the residents and the facility.

- | | | | |
|-----------|---|---|--------------------------|
| Indicator | 1 | Liases with the Director of Nursing and/ or relevant committees to identify the needs of the facility. | <input type="checkbox"/> |
| | 2 | Maintains current resources sufficient to support the provision of information on medicines. | <input type="checkbox"/> |
| | 3 | Responds to medicine information queries promptly and effectively. | <input type="checkbox"/> |
| | 4 | Delivers information on medicines according to the needs and arrangements of the resident and the health care team. | <input type="checkbox"/> |
| | 5 | Recommends appropriate sources of drug information for use by the facility staff. | <input type="checkbox"/> |
| | 6 | Delivers an education program according to agreed arrangements. | <input type="checkbox"/> |

Notes

Maintaining current knowledge of therapeutics helps to provide an efficient medicines information service. To maintain this knowledge, it is useful to be involved in one or more of the following activities: continuing education seminars, conferences, formal postgraduate studies, journal review, in-house clinical meetings, and hospital medical presentations.

Pharmacist should refer to *Dispensing and Counselling* standards for counselling requirements for residents, including the provision of written information such as CMI and the correct use of therapeutic devices.

The education program provides an opportunity to present relevant drug and therapeutics information to facility staff. It could address medication issues specific to the facility, new drugs or therapeutic updates. It also refers to providing information to residents and facility staff promoting the quality use of medicines (such as the storage of medicines, use of compliance aids, and the availability of CMI leaflets and other health-related information).

Criterion 10 The pharmacist’s contract to supply services to the facility addresses all the elements of a comprehensive service.

- | | | | |
|-----------|---|---|--------------------------|
| Indicator | 1 | The contract with the facility clearly defines the various roles and responsibilities of the facility and the pharmacy in terms of the scope of services to be provided. | <input type="checkbox"/> |
| | 2 | The contract with the facility provides all the relevant information (available to the pharmacist) that will be needed by the incoming pharmacist to provide an efficient clinical pharmacy service. | <input type="checkbox"/> |
| | 3 | On commencement or termination of a contract with the facility, the pharmacist hands over relevant information of consenting residents to the pharmacist who will next provide pharmacy services to the facility. | <input type="checkbox"/> |

Guidelines and standards for pharmacists

Criterion 11 The pharmacist is involved in advising the facility about a systematic approach to improving medication-related services within the facility.

Indicator	1	Assists in the evaluation of the medication-related systems within the residential care facility.	<input type="checkbox"/>
	2	Provides regular advice to the residential care facility or relevant committees on relevant quality and safety aspects of medicines within the facility.	<input type="checkbox"/>
	3	Contributes to the development and review of relevant medication policy and procedures.	<input type="checkbox"/>
	4	Documents any recommendations provided to the residential care facility and subsequent outcomes.	<input type="checkbox"/>

Notes

Following are some examples of ways to implement quality improvement.

- Distribute suggestion forms from time to time and encourage residents, facility staff and other members of the medication advisory committee to provide feedback. The use of more formal surveys to seek specific feedback should also be considered.
- Review and/or develop policies for the facility in collaboration with members of the Medication Advisory Committee (MAC) on medication-related issues (eg self-administration of medicines by residents, the use of 'when required'/'prn' medicines).

Depending on the level of contractual agreement, quality improvement activities could include involvement in drug usage evaluation (DUE) activities, being actively involved in quality and safety systems, evaluation of incidents by the MAC, and reviewing appropriate medicine distribution systems.

In some areas, there may be an opportunity to work with Divisions of General Practice on research projects, aged care panels, or regional MACs.

Declaration (Self-assessment and declaration to be completed by all pharmacists providing this service)

Reasons why any indicators are marked 'not applicable'

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.....

.....

Action to be undertaken for each indicator currently not met

.....

.....

.....

.....

I have completed this assessment in a fair and ethical manner, and fulfil the marked indicators in the provision of this service.

Signed Date

Additional information

Pharmacy Services to Residential Care Facilities includes: (i) issue, distribution and storage of medicines; (ii) pharmacist provision of information and advice about medicines with the primary objective of promoting and ensuring quality use of medicines; (iii) communication and transfer of verified information between consumers and health care professionals; and (iv) pharmacists identifying and responding to residents' needs in regard to their medicines, to help them achieve desired health outcomes and prevent adverse medicine events.

It is the right of individual residents to obtain pharmacy services from any pharmacist(s) of their choice.

Pharmacists involved in providing pharmacy services should work closely with the facility's administrative, medical and nursing staff. A written contract between the pharmacist(s) and the facility management will provide clarification that the: (i) management of the facility and the pharmacists involved fully understand the extent and the standard of the service to be provided; and (ii) the management and staff of the facility understand their responsibilities in supporting the provision of the pharmacy services.

A sample contract can be found in the PSA's *Provision of Pharmacy Services to Residential Aged Care Facilities* guidelines.

Quality assurance (QA) is a program of evaluation intended to ensure systems are working well, identify faults, suggest remedial action, and to evaluate new systems. An effective QA program is an essential part of a pharmaceutical service. It should be included in every contract and be appropriate to the level of need.

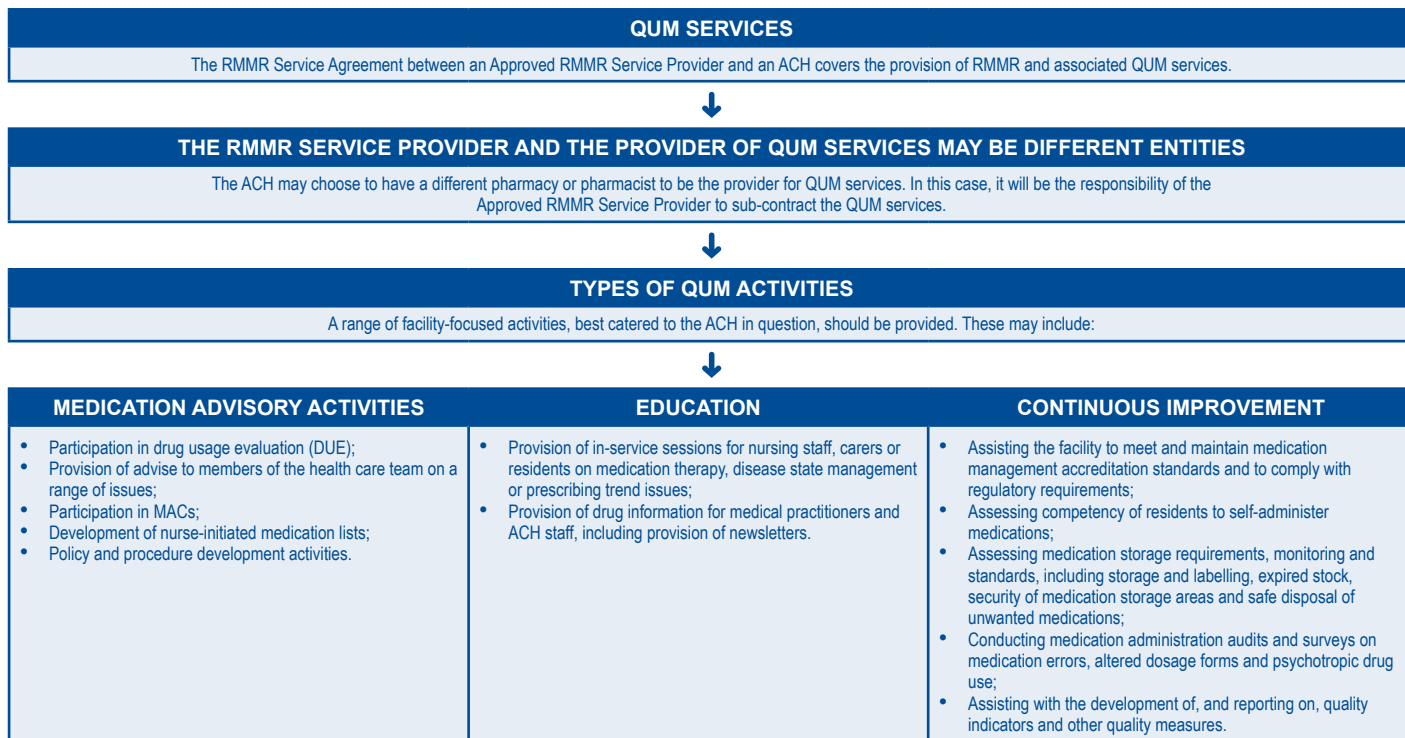
Information resources

- 1 The Society of Hospital Pharmacists of Australia. SHPA Standards of Practice for Clinical Pharmacy. *J Pharm Pract Res* 2005;35(2):122-46.
- 2 The Society of Hospital Pharmacists of Australia. Standards of Practice for Drug Information Services. *Aust J Hosp Pharm* 1999;29(3):171-6.
- 3 Pharmaceutical Society of Australia. *The Provision of Pharmacy Services to Residential Aged Care Facilities*. In: *Australian Pharmaceutical Formulary and Handbook*. 20th ed. Canberra. PSA, 2006.

Appendix A: RMMR Flowchart



Appendix B: QUM Flowchart



Appendix C: Role definition grid of competencies for a pharmacist accredited to conduct medication management reviews

The following role definition grid has been developed in consultation with the Australian Association of Consultant Pharmacy and the Society of Hospital Pharmacists of Australia. It should be read in conjunction with the *Competency Standards for Pharmacists in Australia 2003*. This document is available for download from the PSA's website at: <http://www.psa.org.au/media/compstds2003final.pdf>. Alternatively, hard copies may be obtained through PSA National Product Sales.

The role definition grid details which Functional Areas, Units, Elements and Performance Criteria of the Competency Standards are applicable to those pharmacists undertaking medication management reviews.

Functional Area	Unit	Elements	Performance Criteria	
1. Practise pharmacy in a professional and ethical manner*	All	All	All	
2. Manage work issues and interpersonal relationships in pharmacy practice*	All	All	All	
3. Promote and contribute to optimal use of medicines	3.1	1, 2, 3 4, 5	All (general and supplementary) All	
	3.2	1 2, 3	All All (general and supplementary)	
	3.3	1 2	All All (general)	
6. Provide primary health care	6.1	1 2 3	All (general and supplementary) All All (general and supplementary)	
		6.2	1 2 3 4 5	All (general) All 2, 3, 4S All (general and supplementary) All
			6.3	2 3
	7. Provide medicines and health information and education			7.1 7.2 7.3
	8. Apply organisational skills in the practise of pharmacy*	8.1	All	All
		8.2	All	All
8.3		1, 2, 3, 4, 5	All	
8.4		All	All	

* Denotes a Functional Area containing Units that are universally applicable across all services provided by pharmacists.

Additional competency for conducting drug usage evaluations

3. Promote and contribute to optimal use of medicines	3.3	3	4S
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Additional competencies for planning and managing service delivery

8. Apply organisational skills in the practise of pharmacy*	8.5	1, 2, 3 4, 5	All (supplementary) All (general and supplementary)
	8.6	1, 2, 3, 4, 5	All (general and supplementary)

Guidelines and standards for pharmacists

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