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SUPPLY AND PBS CLAIMING FROM A MEDICATION CHART IN RESIDENTIAL AGED CARE FACILITIES CONSULTATION PAPER

The AMA fully supports the measure for the medication charts in residential aged care facilities (RACFs) to be used as a prescription for PBS purposes. This measure will significantly improve the efficiency of providing medical care to residents of RACFs and increase medication safety.

I have attached a list of 'principles' that the AMA considers should form the basis for implementing the measure.

As a starting point, the National Inpatient Medication Chart (A4 version) recently endorsed by the Australian Commission on Safety and Quality in Health Care would provide a useful basis for designing a chart for RACF purposes, although it would need some modification to suit an aged care environment, for example, to allow it to deal with multiple and repeat prescriptions.

In relation to the consultation paper's specific questions relevant to medical practitioners, we make the following comments.

2(a) In addition to the patient's usual medical practitioner, specialists such as general physicians, geriatricians and psychiatrists should have access to the medication chart to facilitate patient care.

2(b) The patient's usual medical practitioner, or a medical practitioner familiar with the patient's medical condition, should be able to amend the patient's medical chart or to authorise the RACF nurse to do so. In addition, other specialists who the medical practitioner has asked to undertake a consultation with the patient should have the capacity to alter the chart. For example, RACF patients who visit specialists often bring their charts with them and it is more effective and efficient if the specialist can make the alteration at that time, rather than contact the usual medical practitioner who may not be going to the RACF for some time.

2(c) The patient's usual medical practitioner, usually a general practitioner, should take overall responsibility for the medication chart.

2(d) Regarding the IT readiness of RACFs, in our experience, very few are IT-enabled, as described in the consultation paper.

4(a)(b)(c) The chart, whether electronic or paper, should include a place for indicating authorisation of repeats or amendments.

In RACFs it is unlikely for there to be a need to indicate a deferred supply.

The medical practitioner should physically confirm the intention to alter a patient's treatment on the chart or provide some other form of confirmation within a specified time period. In the case of starting a new medication, changing the dose of an existing medication, or ceasing an existing medication, the physical confirmation on the chart should generally occur within 24 hours, although some exceptions depending on the drug or circumstances could be made.

There should be no difference in the authorisation process and mechanism to indicate a medical practitioner's intention between electronic and paper charts.

5(a)(b) Medical practitioners will generally generate a prescription in response from a phone call from the RACF nurse. The medical practitioner will authorise the nurse to make a note on the medication chart and request a medication supply from the pharmacy, and will then follow-up with a written prescription for the pharmacist.

6(a)(b)(c) The AMA recognises that there will always be risks to patients in any change to process involving patient care, although the risks involved in using medication charts for supply and PBS claiming in RACFs are very low. However, the AMA recommends there should be a pre-emptive and proactive education campaign particularly where the existing medication chart is substantially different to the final national version.

We also note that the introduction of chart-based prescribing will require amendment of state legislation that currently requires handwritten PBS prescriptions for opioids. We urge that this becomes the trigger for abolishing the need for handwritten prescriptions for opioids in all settings. This requirement only imposes unnecessary red tape for prescribers and makes no sense in today's electronic recording environment.

Finally, the consultation paper flags that there will be further meetings with stakeholders. We strongly recommend the convening of a working group of medical practitioners, aged care providers, pharmacists and medical practice software providers to enable stakeholders to discuss relevant issues face-to-face. This will help ensure the final product meets stakeholder needs as well as being user-friendly.

Questions regarding this submission should be directed to Georgia Morris on 6270 5466 or gmorris@ama.com.au in the first instance.

Yours sincerely

Dr Wayne Herdy
Chair
AMA Committee for Healthy Ageing

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AMA PRINCIPLES FOR IMPLEMENTATION OF SUPPLY AND PBS CLAIMING FROM A MEDICATION CHART IN RESIDENTIAL AGED CARE FACILITIES

The AMA believes the following key principles must be addressed when implementing, this measure:

- prescribing must remain the responsibility of the medical practitioner;
- the introduction of the medication chart as a PBS prescription in residential aged care must reflect, not dictate, medical practice;
- it should streamline work processes for medical practitioners and integrate with clinical practice management software;
- it should be able to incorporate and track changes which might be frequent and at short notice;
- it should be cost neutral for medical practitioners to implement and use;
- it must be intuitive and simple to use;
- State/Territory drugs and poisons legislation must be nationally consistent and enable the resident's medication chart to be treated as a prescription;
- the use of a single document as a medication chart and a PBS prescription must satisfy PBS regulatory requirements;
- the medication chart should be flexible to accommodate non-PBS prescribing;
- the transition to an electronic medication chart must be planned for and funded if the full benefits to doctors, other health care professionals, aged care providers and most importantly patients are to be realised;
- the electronic medication chart must be equally operable by the software normally used by the prescriber, the dispensing pharmacy and the RACF;
- the system must be able to cater seamlessly for authority scripts and repeats;
- the system must be able to provide authorities for opioids in a timely manner;[1]
- the end product must be appropriate and usable, and attention must be paid to important design elements such as:
  - *recording requirements:* (physicians in Victoria have raised a number of issues in relation to the National Inpatient Medication Chart (NIMC) for private hospitals including the complicated nature of the chart, and the significant amount of manual recording which required and is likely to cause errors);
  - *ease of use*;
  - *the life span of the chart* (suggestions have been made to use a six month chart in RACFs); and
  - *the capacity of the chart to capture repeat and multiple medications* (particularly relevant to the elderly); and
- consideration must also be given as to who owns the chart; previously the medical practitioner was the owner of the script and this should continue.

[1] And other S8 drugs. For drugs of addiction, the maximum quantity authorised is generally for one month's therapy (e.g., one week's therapy with three repeats). In RACFs often supply for a longer period is warranted. Telephone approvals are limited to one month's therapy.