



## Medication management – better practice





Some aged care homes are faced with the difficulty of attracting and retaining the services of general practitioners to provide regular consultations for residents with complex medical needs. Southern Cross Care Macleod Village in Victoria, incorporating Terry Barker Nursing Home and Macleod Hostel, has established a Medical Advisory Committee which has successfully addressed this problem. In May this year, Macleod Village was awarded a Better Practice in Aged Care Award by the Aged Care Standards and Accreditation Agency Ltd.

The Macleod Village Medical Advisory Committee is responsible for the integration of medical care; development of operational policies, provision of advice; quality improvement and education; and communication between all primary care givers. The home attributes many positive outcomes for residents, staff, visiting medical practitioners and stakeholders, to the successful implementation of this initiative.

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## Just a word



**There has been a lot of media reporting in relation to episodes of gastroenteritis and other infectious outbreaks such as norovirus. Regrettably, some reports have fanned the hysteria. How such an approach can be reassuring to residents and relatives is beyond my understanding.**

I know a number of homes have active communications programs in place and have been reassuring residents and their relatives in relation to this issue.

In recent months, we have had episodes of gastroenteritis and norovirus affecting parts of the Australian community. Large hospitals have been affected, as have a number of nursing homes.

The issue for us is not simply whether a nursing home has an outbreak of gastro, norovirus or influenza. The real issue is how the home manages the contagion. Expected outcome 4.7 Infection control requires that a home has "an effective infection control program."

When we assess a home against this expected outcome, we look for evidence that:

- Management can demonstrate its infection control program (plans, procedures, practices, equipment) is effective in identifying and containing infection
- Management has information on infection or other statistics about the effectiveness of its infection control program in identifying, containing and preventing infection
- Staff practice is consistent with Australian Government infection control guidelines.

In our experience when we have found concerns with a home's infection control practices around outbreak management, it is linked to (a) failure to respond to early indicators rapidly; (b) poor communication of outbreak management strategies and; (c) failure to closely monitor staff practices during the outbreak situation.

It is worth considering the advice of the Australian Medical

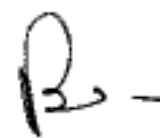
Association earlier this year when gastro was in the news.

The then AMA president, Dr Mukesh Haikerwal, said: "It is inevitable that outbreaks will occur from time to time in frail and vulnerable nursing home populations.

"No matter how perfect the environment and the systems, there will still be outbreaks. Outbreaks of gastroenteritis are commonly related to airborne viruses in addition to food poisoning, so it is important to be sure about the aetiology of such outbreaks.

"The first concern for doctors is to ensure that patients in the affected home are safe. Then all steps must be taken to ensure that the staff and management of the nursing home are supported in their efforts to provide appropriate care to residents and analyse the cause of the outbreak."

We published a special edition of *The Standard* in March dealing with infection control. You can download it from our website, <http://www.accreditation.org.au/TheStandard>



Mark Brandon,  
Chief Executive Officer

## Macleod's medication management

**Issues of legibility in doctor's handwriting on drug charts and in progress notes is often a challenge for nurses and pharmacists. The implementation of a software program to print all medical charts has led to Southern Cross Care Macleod Village in Victoria (incorporating Terry Barker Nursing Home and Macleod Hostel) being awarded a second Better Practice in Aged Care Award.**

With 16 visiting GPs at Macleod Village, the frustrations to registered nurses, medical practitioners and pharmacists were compounding. Frustrations included:

- time taken to administer drugs seen as inefficient use of registered nursing time
- potential errors resulting from illegible handwriting

- use of registered nursing, general practitioner and pharmacy time spent in telephone calls to clarify illegibly charted drug orders
- loss of registered nursing and general practitioner direct care time to residents
- GP frustration expressed at having to re-write multiple drug charts
- number of scripts owing and the sheer volume of scripts required and
- the increased risk of transcription errors when rushing multiple drug charts re-writes.

In 2003, a medical clinical software program was being widely used by general practitioners in their clinical practice. The program was capable of printing drugs directly onto medication charts. Computer generated drug charts were identified as having the potential to enhance safe medication administration and improve efficiencies in the time required to safely complete the medication round.

The program is a simple to use prescription writing, medication and electronic patient management system. It contains a list of practical features to assist GPs and specialists to more easily perform their daily tasks. Specifically, it enables efficient use of a comprehensive medication database with multiple built-in warning systems, drug/drug interaction warnings; drug/allergy warnings; drug/compliance warnings; and prompts for fluvax immunisation reminders; coronary risk calculator; dose calculator; previous prescription list and medication lists.

Crucial to the introduction of the software was consultation with key stakeholders including the Medical Advisory Committee and education for all relevant staff and general practitioners. A roll out strategy was undertaken to fully convert the nursing home drug charts to printed charts then move over to the hostel.

Since implementation of the computerised drug charts, the home can demonstrate the following outcomes:

- time taken to administer the routine medication round has decreased by up to 30 minutes for major rounds (morning and evening)
- increased RN Div1 direct time for resident care

- increased staff satisfaction
- re-focused the primary role of the GP in visiting the resident
- continuous improvement continues with the decision to implement six monthly drug charts across both sites. In some instances, GPs are visiting residents without having to attend to the administrative chore associated with drug charting. 100% of feedback received from GPs fully supportive of the computerised drug charting. They state that they too can spend quality time with their patients
- there have been no resident admissions to hospitals as a result of a medication error
- no errors resulting from illegible handwriting
- reduced number of scripts owing
- no longer receiving phone calls from the pharmacy to clarify medications therapy
- retained and attracted GPs to Macleod.

## The next phase

With the home's ultimate goal to achieve a 'paperless resident medical record', the next phase involves computer generated progress notations. As the level of computer literacy is a barrier to achieving their goal, the home has enlisted a GP to trial the system once processes have been developed.

**For more information on the implementation of the software program at Macleod Village, contact the facility's Manager Diana Cooper by emailing [dcooper@southern-cross.org.au](mailto:dcooper@southern-cross.org.au)**





The Medical Advisory Committee has resulted in positive outcomes including:

- developed a process of peer credentialing for GPs. Once at risk of losing GP membership, the home's GP base now totals 16 credentialed members
- introduction of computer software, leading to improved GP satisfaction, increased consultation and clinical care time with residents, reduced calls from pharmacy to facility and increased staff satisfaction
- regular presentations at the Committee by a geriatrician provides contemporary clinical information and trends in the management of disease in aged care
- development of correspondence for residents to take along with their drug chart to external appointments. The letter requests any medication changes be made to the drug chart. Any changes are immediately forwarded to the pharmacy and medications changed accordingly. This system has also negated the need for visits to the home by GPs to update the medication charts
- reduced number of locum visits – the Committee has endorsed an on-call support system for any resident being palliated or who requires complex pain management
- a 69.6% decrease in the number of admissions to hospital between 1999 and 2005
- 100% attendance at all meetings by general practitioners since commencement.

Manager Diana Cooper said: "Our GPs have told us that the Medical Advisory Committee works because of GP commitment, the frequency of meetings, and that the meetings are professional, structured and organised."

For more information on the Medical Advisory Committee, contact Ms Cooper by emailing [dcooper@southern-cross.org.au](mailto:dcooper@southern-cross.org.au).

## Improved medication management at Brightwater Care Group Edgewater

By Angela Lowe, Care Manager, Brightwater Edgewater Aged Care Facility

The Brightwater Edgewater low care facility in WA is fortunate to have a very supportive GP - Dr Tan, who is very committed to aged care and the importance of effective medication management in residential aged care.

In the past, different health professionals carried out medication reviews at separate times of the year. A recent improvement to this process has been the introduction of a meeting between the registered nurse, pharmacist, care worker and Dr Tan, to review each resident's medication as a collaborative team. This approach ensures that the observations made by the registered nurse and care worker when attending to a resident were considered within the overall medication review. This has resulted in the reduction in the medication taken by many residents, a change in administration times and dose formulations to prevent errors and incorporation of resident preferences. The ongoing involvement of the pharmacist in the review process is of the utmost importance.

Having medical software available at the facility has also assisted the overall medication review process. Dr Tan was approached by the northern aged care panel, Osborne Division of General Practice in May 2006 to evaluate the benefits of on site medical software for medication management as part of improving the overall quality of services by provided by GPs to aged care facilities. Dr Tan trialed software designed specifically for aged care facilities at the Brightwater's Edgewater facility.

Having the correct resources in place proved critical to the success of trialing the software and involved providing Dr Tan with his own office, computer hardware, staff support and IT backup. The trial proved to be a great success in evaluating the merits of having medical software available on site and greatly assisted with the overall improvement in our medication management.

## Wedding belles



When Bonnie Gray, resident of Havilah Hostel in Maryborough, Victoria, could not attend her granddaughter's wedding, they decided to bring the wedding to her!

While Lone and Mark were married earlier in the year, they 'renewed' their vows at a ceremony and reception at the home.

Havilah Hostel's Activities Officer planned the wedding with formal invitations sent to all 64 residents, a cake made by employee Moira, the dining room transformed into a magnificent reception area with balloons, tulle and rose petals and delicious finger food prepared.

Lone was escorted by her father, and Maryborough's celebrant Bob Osborne renewed Lone and Mark's wedding vows with proud grandmother Bonnie and family, friends, residents and staff looking on. The reception followed with champagne, fine food, a delicious wedding cake and entertainment.



## Speaking your language

It is a requirement that homes notify residents and relatives when a site audit is to be conducted by the Agency so that they can arrange to speak with assessors if required.

The Agency provides homes with a 'noticeboard poster' template and a letter template to help homes keep everyone informed.

These documents have now been translated into 15 community languages to ensure residents from culturally and linguistically diverse backgrounds are informed of the site audit and have an opportunity to speak to assessors through an interpreter if required.

Homes that identify in their application for accreditation that their home caters for a group of culturally-specific residents, will receive translated copies of the letter and noticeboard poster.

The information is translated into Arabic, Chinese, Croatian,

Dutch, Finnish, Greek, Hungarian, Italian, Polish, Portuguese, Russian, Serbian, Spanish, Turkish and Vietnamese.

The Centre for Cultural Diversity also provides a valuable service called the Online Resident Handbook.

The handbook enables residential aged care providers to easily compile and publish resident handbooks in multiple languages for a minimal fee of \$200 per year. Languages available are English, Arabic, Chinese (Mandarin), Croatian, Greek, Italian, Macedonian, Maltese, Polish, Russian, Serbian, Spanish, Turkish and Vietnamese.

You can choose from optional content that includes information about low care, high care and extra service; resident participation; legalities; fees and charges; care services; cultural and religious requirements; food

services; recreational activities; and general information, such as laundry, transport and mail.

Handbooks will also automatically include information about quality of care; resident rights and responsibilities; interpreting services; advocacy services; complaints services; harassment and abuse; and privacy and confidentiality.

For information go to [www.culturaldiversity.com.au](http://www.culturaldiversity.com.au).



# Redland Residential Care – not just ‘God’s waiting room’

By Ann Scelly, Physiotherapist, Redland Residential Care, Qld

**Redland Residential Care (RRC) was opened in March 2006 and is a high care facility catering for the needs of 128 residents. The home’s multi-disciplinary team focuses on optimising resident potential by using a holistic approach.**

During the past year the home has had two residents discharged back to their own homes and a further three who have the potential to return to the community.

An 81 year-old gentleman was admitted to Redland Residential Care in March 2006 having been a resident at another facility since 2001. He had been diagnosed with polyneuropathy of unknown origin resulting in partial paralysis of all four limbs. He was confined to wheelchair and required full nursing care. Increased tone made care difficult and impeded his remaining functional movements.

Physiotherapy was conducted daily, at the neurologist’s request, and he was commenced on Baclofen to reduce the tone. As a result of the physical improvement he was progressed from a full hoist to a stand hoist and from a pacific bath to a shower chair.

This allowed his wife, an ex-nurse, to take him home to their new low-set house where she could care for him with minimal community support.

He was discharged in September 2006 and is currently still at home and is thriving on being with his wife.

A 66 year-old lady was admitted to Redland Residential Care from an acute hospital in October 2006. She had been diagnosed with spinal canal stenosis, insulin dependent diabetes, osteoarthritis, hypertension and anxiety and panic disorder. She was virtually immobile due to pain and muscle weakness. Her transport was via an electric wheelchair and a four-wheeled walker for distances of no more than five metres.

A physiotherapy assessment was conducted and a care plan devised which incorporated daily unit-based exercises, twice weekly ‘gym’ group attendance and participation in the falls prevention group. The groups were also used as a social setting where residents could receive peer support and generally have fun!

In March 2007 she was discharged home to her husband – she walked out of Redland Residential Care using her walking aid – her wheelchair had been discarded.

She was eager to continue her exercise regime so a home program was formulated. News has come in that she is happy in the community, regularly goes out shopping and is enjoying her new-found level of independence.

## Cruising – again



On the June long weekend, storms ravaged the Central Coast of NSW causing major flooding. Wyong Aged Care Facility evacuated 65 frail-aged residents and 17 staff, as the river rose and cut off access.

Residents and staff were evacuated in boats by the SES and Ambulance Service. The process took about six hours, with the residents well prepared for what was to happen and all remained calm throughout the experience.

The non-ambulant, more dependant residents were transferred to Gosford Hospital, while the more mobile residents were sent to Wyong Golf Club. There they enjoyed watching the football on a big screen TV, ordering drinks from the bar and playing the pokies.

In retrospect, the residents had an amazing adventure and to keep with this positive experience and as a way of debriefing after the flood, the staff decided to take the residents on a ‘cruise to Hawaii’.

The cruise was so successful, that the residents will be taking their passports and eagerly getting them stamped at their next port of call – to the North Pole for a winter Christmas celebration.

# Focus on medication management from *Results and processes guide*

Each month we are profiling some of the expected outcomes of the Accreditation Standards. This month we focus on expected outcome 3.5 Independence.

## Assessors look for the following results:

- Management demonstrates residents' medication is managed safely and correctly.
- Management can demonstrate staff compliance with the medication management system.
- Management can demonstrate the medication management system is safe, according to relevant legislation, regulatory requirements, professional standards and guidelines.
- Residents/representatives confirm they are satisfied that medication is managed safely and correctly.

## Assessors consider the following processes:

- Are policies and procedures documented and made available to staff?
- How are staff practices developed and monitored to ensure understanding and compliance with processes and procedures? For example, are quality assurance audits conducted and reviewed, and does supervision of staff exist?
- How does the home ensure regular evaluation and review of residents' medication needs and preferences, undertaken by a pharmacist or medical officer? For example, does this include consideration of:
  - o allergies
  - o each resident's cognitive ability
  - o each resident's pain management needs
  - o medication side effects?
- Is there proper recording and ordering of medication orders? For example, are:
  - o orders current, legible, signed and dated, with the dose and time prescribed
  - o urgent and out-of-hours orders catered for?
- Does the storage of medication include:
  - o a level of security of medications appropriate for the medication and circumstances
  - o refrigeration of medications as appropriate
  - o dating of opened medications as appropriate (creams, ointments, etc)
  - o correct and safe storage of medications for residents who self-administer?
- Does administration of medications to residents by staff include:
  - o the correct identification of residents
  - o ensuring residents receive the correct medication, in the correct dose via the correct route and at the correct time
  - o assessment of the skills and knowledge of all staff administering medications?

- Does administration of medications by residents include:
  - o assessment of the resident's ability to self-administer
  - o education for the resident to self-administer in a safe and correct manner
  - o regular monitoring of the resident self-administering
  - o consultation with residents/representatives and others (medical and health professionals) about the self-administration?
- How does the home ensure regular evaluation and review of the medication management system including:
  - o processes for reviewing residents' medications (including the use of PRN (Pro Re Nata – as necessary or as required), drug interactions, and the use of nurse-initiated medications as appropriate)
  - o regular review/use of multidisciplinary teams where possible
  - o medication ordering processes, including emergency supplies
  - o correctness of medications against medication records and orders
  - o medication administration processes including for residents who self-administer?
- How does the home ensure medication incidents are documented, reported and appropriately addressed?
- How does the home ensure appropriate disposal of medications including that of ceased, damaged and out-of-date medications?

## Links to related expected outcomes

### Expected outcome 2.1 Continuous improvement

Medication management data (which may include prevalence of medication errors or use of psychotropic medications) may be used by the home to identify opportunities for improvement within the home in relation to medication management.

### Expected outcome 2.2 Regulatory compliance

There are various state and territory laws and guidelines which govern medication management practices. Whilst assessors do not assess compliance with such requirements, the home should be able to demonstrate how its processes are in accordance with relevant protocols and are hence 'correct'.

### Expected outcome 1.7 Inventory and equipment

Problems with the ordering, storage and disposal of medications may indicate gaps in expected outcome 1.7 Inventory and equipment.

### Other expected outcomes of Standard Two

Various expected outcomes relating to health and personal care may involve the administration of medication. Therefore, identification of gaps within these expected outcomes (for example, relating to pain management, continence management or sleep) may indicate subsequent gaps in the home's systems relating to medication management.

For more information on the results and processes of other expected outcomes, you can download the Results and processes guide from the Agency's website, (97 pages) or you can purchase a copy of 'The Accreditation Essentials'. Go to [www.accreditation.org.au](http://www.accreditation.org.au) and click on 'Resources for sale: Accreditation essentials'.

# Director profile - Dr Michael Bollen AM



◀ Dr  
Michael  
Bollen

*The Standard* is featuring a profile on the directors of the Agency.

This month, we profile Dr Michael Bollen AM.

Dr Michael Bollen was appointed as a Director of the Aged Care Standards and Accreditation Agency Ltd in June 2004 and recently reappointed for a further three years.

His background includes:

- extensive experience in health care including 25 years as a family doctor and as the foundation director of the first community health centre at Ingle Farm in South Australia where he first became aware of the possibilities of community based supportive care for older people
- Principal of BMP Healthcare Consulting, a small company that undertakes health related management consulting
- Chairman of
  - the Victorian Worksafe Independent Medical

Examiners Selection and Quality Assurance Committee

- a Commonwealth Government committee overseeing changes to Complementary Medicine in Australia.
- Previously a commissioner in the SA Health Commission, Chairman of the Department of Primary and Emergency Care and Director of Primary Care at John Hunter Hospital, Newcastle NSW, Secretary General of the Royal Australian College of General Practitioners, a board member of Medibank Private and a member of the National Health and Medical Research Council as well as membership of a number of other government and professional committees.

## What perspective/historical experience do you bring with you?

When I was a GP, I considered that older people should have the right to be assisted to stay in their own home or independent residential accommodation for as long as possible with well coordinated support from community services. I was distressed by the poor standards of care and accommodation provided to people who had entrusted me with their care at some of the aged care facilities that I visited. I thought that aged care facilities should reach out to the

community to provide better and safer support for independent living rather than simply provide institutionalised care.

## What has been the biggest change in aged care over the past ten years?

I now can see improvements in community-based care starting to occur but I consider there is a need for better continuity of care, focussed on individual need. I am pleased to see recognition of the need for dementia specific care and a better understanding of the needs of the family in coping with dementia.

## Where do you think the industry will be in ten years' time?

The industry should be in a position to enable those requiring aged care support a wider choice of service providers rather than having to accept the place that has a vacancy. Independent living should be the norm for all who wish it, either in their own homes or in specific residential facilities but with wide ranging support readily available. Well planned and programmed preventive care supported by well trained nurses, interested GPs and other health service providers will enable older people to remain independent and in better health for longer. Access to these services should be part of a more broadly based health insurance program linked to superannuation as well as public funding.



The Aged Care

Standards and Accreditation Agency Ltd

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