The Pharmacy Guild of Australia

SUBMISSION

Royal Commission into Aged Care Quality and Safety

Enhancing safety and quality use of medicines through community pharmacy

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1. INTRODUCTION

The Pharmacy Guild of Australia (the Guild) is the national peak organisation representing community pharmacy. It supports community pharmacy in its role of delivering quality health outcomes for all Australians. It strives to promote, maintain and support community pharmacies as the appropriate providers of primary health care to the community through optimum therapeutic use of medicines, medicines management and related services.

Community pharmacy is consistently seen by the Australian public as a trusted and valued part of our nation's healthcare system. Community pharmacy in Australia is an essential, highly trusted and primary healthcare destination. Owned by pharmacists, community pharmacies exist in well-distributed and accessible locations, and often operate over extended hours, seven days a week in urban, rural and remote areas. The community pharmacy network in Australia is an essential, highly trusted and the most accessible primary healthcare destination. It provides timely, convenient and affordable access to the quality and safe provision of medicines and healthcare services by pharmacists who are highly skilled and qualified health professionals.

94% of community pharmacies are accredited under the Quality Care Pharmacy Program (QCPP) to ensure they provide safe, consistent and quality pharmacy services. QCPP is a quality assurance program that assesses pharmacies to the Australian Standard AS85000:2011 Quality Care Pharmacy Standard. From July 2020, pharmacies will be accredited to AS85000:2017 and the new QCPP requirements which will have strengthened requirements to address specific clinical governance principles.

In Australian capital cities, on average, a person is located under 1 km from the nearest pharmacy. Outside the capital cities, Australians are 6.4 km on average from their nearest pharmacy.[1] In relation to location of community pharmacies and residential care facilities:

- 99% of residential aged care facilities have access to at least one pharmacy within 2.5 km radius in metropolitan areas and 93% in regional areas.
- 78% of residential facilities across Australia have access to at least two community pharmacies within 2.5 km radius
- 80% of residential facilities have access to three pharmacies within 10 km radius.[2]

The network of over 5,700 equitably distributed community pharmacies play a pivotal role in the delivery of the National Medicines Policy, by ensuring timely access to safe, effective and affordable medicines under the Pharmaceutical Benefits Scheme (PBS) for all Australians. Quality Use of Medicines (QUM) is an important pillar of Australian National Medicines Policy, with community pharmacy having a vital role supporting ageing Australians who are at high risk of medication misadventure due to multiple co-morbidities and complex medicine regimens.

Community pharmacists are highly qualified and skilled healthcare professionals who provide timely, convenient and affordable access to the quality and safe provision of medicines and healthcare services. Community pharmacists provide an array of services which extend well beyond the provision of medicines and as such, pharmacies are often the first contact point of the primary healthcare system for many people.

[1] Geospatial analysis MacroPlan Dimasi 2016
[2] Geospatial analysis The Pharmacy Guild of Australia 2019

Some of the services offered include:

Medicines management and Quality Use of Medicines activities

- Medication Management Reviews (in-pharmacy, home and residential care facilities)
- QUM activities in residential aged care facilities
- Dose Administration Aids (DAAs)
- Staged Supply
- Palliative care support services

Public/population health activities

- Immunisation services
- Needle and Syringe Programs
- Opioid Treatment Programs
- Preventative health and wellbeing

Screening, management, monitoring and support of health conditions

- Diabetes management services including NDSS access
- Respiratory services
- Wound care support and products
- Pain management services
- Common ailments
- Mobility and independent living aids, equipment and products

The Guild recognises the importance of improving the health status of Australians and promotes equitable access to medicines and pharmacy services to all Australians, especially the ageing population and those with chronic health conditions.

Community pharmacists are well aware of the special needs of older Australians and the need to provide and facilitate support services and longer-term strategies. Pharmacies assist older Australians to continue to live independently in the community for as long as possible before needing to move to residential aged care facilities. The Guild is committed to working in collaboration with other healthcare professionals, aged care community and carer organisations, and all levels of Government in Australia to improve safe and quality healthcare services and health infrastructure that aim to support the ageing population to maintain their independence and their quality of life.

The Guild welcomes the opportunity to provide the submission to the Royal Commission into Aged Care Quality and Safety. This submission outlines the current role of community pharmacy in working with older Australians who have entered residential care as well as those living independently in the community. The submission further explores the problems facing community pharmacists and offers solutions to enhancing safety and the quality use of medicines delivered through community pharmacies across both residential and community aged care.

2. EXECUTIVE SUMMARY

The growing ageing population has highlighted the need to ensure that older Australians receive the best possible health care whether they live at home or in aged care facilities. This care not only should ensure their optimum health outcomes and wellbeing, but also reduce pressure on health budgets.

As Australians progress through the ageing cycle starting from in-home support, through to residential aged care and end of life care, the need to access medicines, in particular urgent medicines, and pharmacist care increases and it is paramount that our elderly population have access to their community pharmacist. The Guild believes the skills and knowledge of community pharmacists can be better applied in areas ranging from medication management through to the provision of a range of health services, both in the home and in aged care facilities.

Medicines play a critical role in the quality of life of older people living in residential aged care as well as those ageing in the community. Consistent standards and adequate and well-targeted funding for pharmacist professional support in relation to medicines and their management is critical to the safe and effective use of medicines by older Australians. Consistent standards built on a foundation of a best practice approach will ensure quality and safety objectives are met in this high needs population. Medicines management services should span all settings where the ageing population may access services, including residential aged care and home-based care (including through home-care packages).

The current medicine management arrangement is fragmented and inefficient. Currently Residential Aged Care Facilities (RACFs) may have arrangements in place with up to four different pharmacy service providers for various functions such as:

- Regular supply of medicines and medicines management systems (e.g. Dose Administration Aids)
- Urgent medicine supply (e.g. antibiotics, morphine)
- Residential Medication Management Review (RMMRs); and
- Quality Use of Medicines (QUM) support.

Currently, contracts for medicine management services (i.e. RMMRs and QUM) are held by a small number of providers, resulting in many RACFs being serviced by fly-in/fly-out providers rather than by local providers. In addition, many medicine supply contracts are being provided by suppliers that are not based in the same town or suburb as the RACF. In these situations, the supplier does not provide urgent medicine support or advice and as such, the RACF commonly relies on the local pharmacy to fill this gap.

This fragmentation of care can negatively affect the quality of service, medicine management, and continuity of care provided to residents. Moreover, due to funding pressures and tight budgets, more often than not, the contracts are awarded to suppliers that can provide the service at the lowest cost, rather than a service of high quality that meets the healthcare needs of the residents.

The fragmentation and inefficiency of the current system increases the possibility of medicine misadventure, places the residents' health at risk and compromises the quality use of medicines.

It is important to ensure that community pharmacies are not financially disadvantaged by their commitment to improving the health outcomes of residents in aged care facilities. This financial burden on the community pharmacy undermines the pharmacy's resourcing and capability to best support medicines safety and optimal medication management in aged care facilities. In addition, some facilities expect and require pharmacy contractors to provide additional and unremunerated components and services such as medicine trolleys, software programs and medicines education services.

The proposals to embed pharmacists within residential aged care facilities, independent of the medicine dispensing service, would simply lead to duplication of services and fragmentation of care. The best way to integrate community pharmacy in aged care facilities is through an outreach program using local community pharmacists. This would ensure better care and flexibility, and see patients have potential access to the full range of a pharmacy's expertise and infrastructure.

In all areas – including rural, regional and remote locations - community pharmacy should be used to optimise access to early intervention and referral for the diagnosis of dementia. In addition, funding needs to be expanded to community pharmacists to allow for earlier medical and social interventions, and to play a vital role in the referral pathway to general practice.

The Guild also believes there needs to be more flexible funding in home care packages to allow for the expanded scope of services that community pharmacies provide. The services which could be offered through expanded funding include post-discharge medicines reconciliation services and personalised medicine management plans that are delivered collaboratively to reduce adverse medicine events and hospital admissions and readmissions.

There is also a need to reform medicines provision in residential aged care facilities. This dispensing should be via the mandatory use of a standard national residential medicine chart[3], ideally on a digital prescribing platform that still allows patients a choice of the dispensing pharmacy. A single digital platform for all medicine-related matters would provide efficiencies that would enable all professionals in the medicine management pathway[4] to better use their skills to improve patient outcomes.

Quality use of medicines can be further enhanced by strengthening the connection between local community pharmacies and the aged care facilities. Many residents in RACF need care seven days a week. It is essential that urgent medicines, medicine services, clinical advice and review by a pharmacist are available to all aged Australians when they need it. The Guild strongly believes that best practice is to integrate the local community pharmacy with RACFs through an outreach model of care to meet each individual resident's medicine management needs.

The Guild believes that rather than RMMRs being provided every two years, it is more beneficial to the resident to have an initial review, including medication reconciliation, on entry into the RACF, and subsequent clinical reviews and services provided by the community pharmacist based on the resident's clinical need e.g. recent fall, post-hospital discharge, changes to therapy including prescribing of anti-psychotics.

The important role of local community pharmacies in providing comprehensive support to RACFs must be supported to ensure that efficient and effective care is provided when it is needed.

It is a challenge to provide adequate, efficient and quality health and aged care services for older Australians due to an increasing proportion of the older population in Australia. Polypharmacy and the alarming rates of medicine-related problems are crucial factors resulting in poor health outcomes, admission to hospital and residential aged care facilities.

[3] https://www.safetyandquality.gov.au/our-work/medication-safety/national-residential-medication-chart#benefits-of-using-the-nrmc
[4] https://www.shpa.org.au/sites/default/files/uploaded-content/field_f_content_file/56._understanding_the_med_management_pathway.pdf

Therefore, the Guild supports and recommends policies and systems that:

- promote safe and high-quality health and aged care;
- sustain independence and quality of life;
- support older people to live independently in the community for as long as possible before needing to move to residential aged care facilities; and
- have the potential to reduce admissions to hospital and residential aged care facilities and poor health outcomes due to medicine misadventure
- invest taxpayer funds in existing networks to better deliver health outcomes rather than duplicating or fragmenting care

Community pharmacies are ideally placed to support Australians ageing in their homes and in aged care facilities and to help to lower their cost of care to the broader health system, including those who are most at risk of frequent hospitalisation. The Guild draws the Commission's attention to pharmacists' expert knowledge in medicines and medicines management and the current infrastructure and network of community pharmacy.

Recently completed market research conducted for the Guild's *Community Pharmacy 2025* planning project has shown that Australians are highly supportive of community pharmacy delivering a range of in-home services to the ageing, reflecting the high trust and value that the Australian public place in their local community pharmacies.

With appropriate funding, community pharmacy could provide an individualised Aged Care Package to support older people to live independently at home for as long as possible and to support them if and when they move into residential aged care facilities as well as those requiring palliative care.

2.1 Recommendations

Funding

1. Funds for medicine management services in RACFs should be reformed to ensure all pharmaceutical care is provided through facility based pharmacy aged care package.

2. The Aged Care Funding Instrument (ACFI) and other direct-to-provider funds should be reviewed to ensure their efficiency is maximised within the current system including payment for comprehensive medicines management systems (DAAs) quarantined to support RACF to administer.

3. Funding model solutions and procurement reform for RACFs must involve consideration of the 'true total costs' – be it time taken for health professionals to communicate, resource materials or the cost of infrastructure.

4. The Government and independent advisory groups such as the Pharmaceutical Benefits Advisory Committee must ensure that policy decisions which affect the remuneration of community pharmacy for subsidised products or services are not considered in isolation but with consideration of any flow on effects to the capability of providing other services such as aged care support.

5. Procurement and tendering guidelines should be developed so that key service requirements are not compromised over other indirect 'value add' components e.g. paying for drug trolleys or IT systems.

6. The local community pharmacy should be used as a first preference to support efficiencies with timely access and continuity of care, given that 99% of residential aged care facilities have access to at least one community pharmacy within 2.5 km radius in metropolitan areas and 93% in regional areas, 78% of facilities across Australia have access to at least two pharmacies within 2.5 km radius and 80% of facilities have access to at least three pharmacies within 10 km radius.

RMMRs and QUM

7. The Aged Care Quality Standards should reflect the integral nature of dispensing of medicines and QUM functions to ensure holistic patient care.

8. Local community pharmacies, GPs and other health practitioners, should be encouraged and supported to service local facilities in their community.

9. RACF clinical governance frameworks should include a clinical advisory committee consisting of a GP, community pharmacist, allied health professional and consumer representative, with authority to advise on the safety and quality of clinical care, including medicine management.

10. Due to the complexity, inefficiencies, fragmentation and costs of RMMR/QUM programs, these services should be replaced with a more holistic and flexible funding model through facility based pharmacy aged care package which is based on clinical need.

Medicines dispensing management workflow

11. The dispensing of all medicines in RACFs should be via the mandatory use of a standardised NRMC in a digital prescribing platform.

12. A real time notification of medicine changes for RACF staff and the supplying contract pharmacy should be integral to the digital NRMC. This single digital platform for all medicine-related matters would provide efficiencies enabling all professionals in the medicine management pathway to better use their skills to improve patient outcomes.

13. Legislative change is required to allow prescribers and pharmacists to prescribe and dispense all medicines from a NRMC, including Schedule 8 medicines, PBS authority required items requiring prior approval, and S100 Highly Specialised Drugs.

ICT and system software synergy

14. All pharmacy-based medicine management software platforms should be consistent and conformant for charting, signing, supplying and packing medicines to ensure the resident's medicine management is optimised.

Use of psychotropic medicines as chemical restraint

15. Pharmacists should be provided with autonomous prescribing rights as this will give pharmacists the right to deprescribe and prescribe medicines for patients in RACFs in a timely manner. This will address issues of chemical restraints and provide timely access to medicines in times of urgent need.

Embedding non-dispensing pharmacists in aged care facilities

16. The government-funded trials of embedding pharmacists in residential aged care facilities should assess the cost-effectiveness, economic benefit and outcomes from a patient, and workforce perspective on various options including a comparison with a community pharmacy outreach model.

17. The service roles should not be duplicated, and patient care must not be fragmented by employment of embedded pharmacists. The best way to integrate community pharmacy with RACFs is by an outreach program using local community pharmacists via facility based pharmacy aged care package.

Continence care

18. Consideration should be given to funding the pharmacy continence care services that promote bladder and bowel health across the lifespan and improve access to quality continence care.

Dementia care

19. The implementation of a dementia-specific, collaborative model of care for the person with dementia, supported by a medicine management plan that is agreed to by the collaborative team i.e. the GP, the community pharmacy, RACF nursing and care staff, the patient and, as needed, the patient's carer. The focus would be to actively encourage and support wellbeing through regular interaction and collaboration with the patient's trusted health professionals.

20. Community pharmacy should be used to optimise access to early intervention and referral for the diagnosis of dementia, including to people living in rural and regional areas.

21. There is significant funding to support GPs to make a more timely diagnosis of dementia, allowing opportunities for early medical and social interventions. However, the funding restricts consumers' access to early intervention activities to general practice only. Consideration should be given to expanding the funding to community pharmacists to give them opportunities for earlier health and social interventions, as well as playing a vital role in the referral pathway to general practice.

22. Community pharmacy should be included as 'healthcare facility' where a patient can access telehealth and video conference to a specialist at another location. This will help address some of the barriers to accessing health care, including dementia-related medical services for patients in rural, regional and outer metropolitan areas.

23. Community pharmacists and pharmacy staff should receive training to help them identify the signs of elderly abuse. This training could be included as part of the broader training to enable pharmacies to become dementia friendly health destinations.

Palliative Care

24. There needs to be a recognition of the potential role of a community pharmacist within a multidisciplinary team to assist patients requiring palliative care to remain in their home and receive the best care possible.

25. Consideration should be given to funding a community pharmacist's involvement in structured Care Plan arrangements for palliative care patients and to ensure minimum stock levels of essential palliative care medicines are available.

26. Access to effective palliative care medicines requires consistent legislation between States and Territories to ensure access is not hampered.

27. Relevant agencies should consider how to minimise cross-border barriers and streamline access to essential medicines for palliative care patients.

28. There would be significant benefits to the Government and to the patients and their families to fund DAAs services as part of palliative care services.

29. Funding should be available for pharmacists' visits to a hospice to deliver QUM services for palliative care and pain management as identified by the facility similar to that provided in the UK by the National Health Service.

30. Medicines that are not specifically registered on the Australian Register of Therapeutic Goods (ARTG) for palliation but registered for other uses and indications should be identified, and sponsors of these medicines should be encouraged to update the TGA-approved indications and the list on PBS for palliative care.

31. All palliative care medicines should be PBS listed in the best interest of patients requiring palliative care treatment in the community.

Reform to home care packages

32. Community based pharmacy aged care packages should be implemented to support older Australians to live at home for longer.

33. Medicine management and support should be recognised as an approved core service in home care packages.

34. More flexible funding in home care packages to allow for the various scope of services that community pharmacies can offer including:
    - access to local community pharmacist and their clinical expertise
    - medicine management and medicines reconciliation services based on clinical need
    - personalised medicine management plans that are delivered collaboratively (with prescribers and care providers) that can significantly reduce adverse medicine events and hospital admissions and re-admissions; and
    - home delivery of medicines and other pharmacy items for patients who have limited mobility or carer availability to assist including collection and disposal of unwanted medicines accordance with regulations and guidelines, preventing incidences of medicine misadventure.

3. ROLE OF COMMUNITY PHARMACY IN RESIDENTIAL AGED CARE

3.1 Medicines Supply

Community pharmacies are contracted to dispense medicines and associated medicines management services to approximately 3,000 residential aged care facilities (RACFs) around Australia. These services include the packing of medicines into DAAs, daily deliveries to the RACF, and access to a pharmacist, including after-hours.

Dose Administration Aids (DAAs)

Community pharmacies working with RACFs have long adopted a best practice approach of dispensing medicines to aged care residents in individualised DAAs. DAAs are well-sealed, tamper-evident devices that allow individual medicine doses to be organised according to the prescribed dose schedule.

Many community pharmacies provide DAAs as part of their contracts with residential aged care facilities. The use of blister packaging in the supply of medicines to aged care facilities improves accuracy in medicine administration and improves the quality use of medicines. They also allow staff additional time to provide quality care to patients. The use of DAAs is considered to be best practice for all aged care facilities to meet medicine administration and accreditation requirements. DAAs are not just "aids" but are an integral part of a medication management system that allows for rigorous checking of medicines and their administration.

3.1.1. Supply arrangement of Pharmaceutical Benefits Scheme (PBS) medicines in residential aged care facilities

Due to PBS claiming requirements and the fact that medicine administration charts were used in RACFs to manage the administration of medicines, the Guild identified a need to combine the medicine chart and the PBS prescription. When negotiating the Fifth Community Pharmacy Agreement the Guild included a program to develop a National Residential Medication Chart (NRMC). The Australian Commission on Safety and Quality in Healthcare (ACSQHC) was commissioned to develop, test and evaluate a standardised national medication chart during 2013-14 funded through the 5CPA.

While it took some time for Commonwealth and all State/Territories governments to make the necessary changes to the relevant legislation, the introduction of the NRMC to residential aged care facilities has delivered some efficiencies by reducing costs, and most importantly has improved patient outcomes.[5]

One of the main objectives of the NRMCs is to enable the prescribing and dispensing of most medicines, and PBS/RPBS claiming by pharmacies where applicable, directly from the NRMC without the need for a separate prescription to be written.

However, certain medicines still require a traditional written prescription, such as:

- PBS Authority Required items requiring prior approval (written and telephone approval, including PBS/RPBS items with increased quantities)
- PBS items only available under Section 100, for example Highly Specialised Drugs
- Controlled drugs ('Schedule 8' medicines)

[5] https://www.safetyandquality.gov.au/our-work/medication-safety/national-residential-medication-chart

This can have a negative effect on optimal medicine management for residents for example, in many instances there may be a delay in dispensing of medicines as the doctor may have prescribed an opioid on a chart, but had forgotten to provide a written prescription. In rural and remote areas, the requirement for a traditional written prescription in addition to the NRMC, is impacted by the reduced number and availability of prescribers. Therefore, legislative change is required for prescribers and pharmacists to prescribe and dispense all medicines from a NRMC, including Schedule 8 medicines, PBS authority required items requiring prior approval, and S100 Highly Specialised Drugs. Ideally the NRMC should be digital to have electronic prescribing of medicines on the electronic chart.

3.1.2. Functions required of a supply pharmacy

The following list identifies some of the common functions and responsibilities included in the average contract between a supply pharmacy and a RACF. This list has been created from a selection of actual contracts.

Medication Management Cycle	
Review of medicine order	• Undertake medicines reconciliation for new residents, check and record medications brought into the RACF • Ascertain the full directions for use and label the medicines accordingly • Review Residential Medication Records • Pinpoint any possible discrepancies or inadequacies in the resident's therapy (i.e. regular medicine management reviews) • Initiate, interview and maintain current and new resident medication records to ensure accuracy of medicines supplied in accordance with PSA's Professional Practice Standards
Issue of medicine	• Dispense all medicines • Label the container so that whenever possible the relevant details are visible to RACF staff • Dispense medicines for residents in DAAs. Medicines to be packed into DAAs at no charge to the resident, and no charge to be made for any changes necessary during any week
Provision of medicine information	• Ensure the appropriate counselling on each type of medicine used by each resident is given to RACF staff • Provide counselling to residents about their medicines on request • Respond to drug information queries • Maintain a library of texts, references and journals sufficient to be able to respond to information requests • Ensure quality use of medicines is maintained by providing Consumer Medicine Information (CMI) as per PSA guidelines
Distribution and storage of medicine	• Provide a regular, timetabled service sufficient to cover the requirements of the RACF, including as a minimum a once daily delivery Monday to Friday inclusive • Deliver orders to the RACF and hand to nursing staff on duty • Provide an emergency service and an after-hours consultation service to cover extraordinary circumstances at no additional charge

	• Advise on appropriate environmental storage conditions of all pharmaceuticals kept at the RACF • Provide a 24 hour on-call service to deal with any emergency medicine needs. This will be provided along with all other medicine management assistance at no charge to the RACF • Collect and dispose of any unused, discontinued or expired medicines in accordance with recommended guidelines for the disposal of scheduled medicines • Ensure medicines being delivered are kept in optimum condition with special reference to cold chain procedures
Decision to prescribe medicine	• Provide recommendations for appropriate changes to drug therapy as necessary
Record medicine (prescribe)	• Report any findings and changes made in consultation with the medical practitioner to the RACF staff and record such changes on the medication chart and history
Monitor for response	• Take reasonable steps to identify suspected adverse reactions to medicines • Confer with the medical practitioner to confirm any suspected adverse drug reaction • Where appropriate, complete the "Record of a Suspected Adverse Drug Reaction" (“blue card”) and dispatch to TGA
Transfer of verified information	• Initiate and maintain the resident’s medication records by maintaining a medication chart and dosing chart • Check, within 24 hours of the notification of departure of a resident, that RACF has followed the outlined procedures on handling their medicines • Communicate information concerning any medicines-related matter quickly and effectively to the RACF or medical practitioner as appropriate • Note in history that an adverse drug reaction report has been lodged
Other activities	
Patient specific administration	• Deliver a complete prescription management service i.e. store prescriptions/repeats, request prescriptions from prescribers, maintain PBS Safety Net record, follow-up “owing prescriptions” from prescribers • Be aware of all resident entitlements (pension number) as regards payments for all dispensed medicines and price accordingly • Obtain and update complete pension and safety net entitlement details for all residents • The pharmacist appointed to the RACF will reconcile and synchronise all prescriptions and liaise directly with medical practitioners to obtain new and owing prescriptions • Maintain records for at least six months of all medicines dispensed and packed in a DAA under the resident’s name with the date of filing, the initials of both the person who filled it and of the

	pharmacist who checked it to ensure the accuracy of medication packing and distribution processes
Liaison with RACF	• Develop and maintain good communication with personnel • Appoint a dedicated customer service officer to the RACF to ensure a high degree of personalised service and attention to detail. This customer service officer will visit the RACF on a regular basis, using this time to audit, review service level standards and discuss quality initiatives with the RACF • Provide an annual education program to the staff of the Facility regarding the services provided by the pharmacy
Governance	• Be involved in development of pharmacy policies at the RACF, e.g. medicine storage, distribution, documentation, imprest stocks, frequency of ordering • Participate in and contribute to committees of the RACF, e.g. Medication Advisory Committee (MAC) • Not in any way misrepresent to a resident that the resident must acquire their medicines from the pharmacy
Equipment	• Equipment supplied to the RACF may include fixtures and fittings, dose administration hardware, diagnostic equipment computer hardware and may vary from time to time
Administration	• Develop an efficient accounting system in conjunction with the RACF and render bills promptly • Provide an individual monthly statement detailing all medicine and other pharmacy items supplied during that month to each resident • Insure pharmacy and pharmacist for professional indemnity and public liability • Maintain a cloud-based database which records the particulars and medication profiles of each resident along with specifics of the RACF • Supply RACF with DAAs managed by software systems for improved productivity, streamlined procedures and enhanced safety (pharmacy has to buy this special software) • Not charge DAA packaging fees. If errors are made in dispensing medicines into blister packs, repackaging cost will be borne by the pharmacy • Ensure that all Private Prescription Dispensing and over the counter products are priced competitively • Ensure that each pharmacy employee or subcontractors, over 16 years of age and who will reasonably have access to care recipients in the RACF, will at all times hold a police certificate which has been issued in the past three years • Provide a statutory declaration to RACF if a relevant employee or subcontractor has been a permanent resident in another country other than Australia since turning 16 years of age

Quality Assurance	• Pharmacy will conduct its own internal quality assurance programs • Have an incident reporting system in place designed to promote continuous quality improvement, but which can be modified and amended to comply with any previously existing systems of individual facilities • Provide a complete medication management system that ensures each RACF meets, and exceeds Accreditation Standards and Guidelines • Provide manuals detailing all aspects of medication management, which will satisfy the need for documentation required under the Accreditation Standards and Guidelines • In accordance with QUM and RMMR agreement, conduct a quarterly audit on storage and medication systems in use at the RACF

The above list clearly demonstrates that the process of 'supply and dispensing' also includes all aspects of clinical review and monitoring, and what is expected from a RACF.

3.1.2.1 A day in the life of a pharmacist working with a RACF

The processes and actions that have direct impact on a patient's health described below are performed by community pharmacy on a daily basis. This list has been developed following interviews with pharmacists providing dispensing services.

When visiting the facility

1. Attend for Schedule 8 (Controlled Drugs) destruction on a fortnightly basis (generally 40 mins per visit).

2. Monitor stock of non-packed products to ensure they are not expired, that they are stored correctly - both in terms of legislation and manufacturer recommendations (generally 45 mins per visit).

3. Attend Medicine Advisory Committee (MAC) meetings (monthly; each meeting is approx. 1 hour).

4. Medication chart audits, performed quarterly. (Audits are not clinical reviews, but a quality assurance process)

5. Liaise with doctor for *Continuous Monitoring Eligibility Assessment* form (every 6 months) to enable continued supply of NDSS to ensure monitoring of blood glucose levels[6].

6. Following up with doctor and the registered nurse when patient is charted a new medicine with existing allergies.

7. Calling previous pharmacy for medicine floats, safety net reports and prescriptions.

[6] https://www.ndss.com.au/wp-content/uploads/forms/blood-glucose-test-strip-6-month-access-approval-form.pdf

8. Keep an open line of communication with the registered nurses offering advice and confirming chart changes, patient non packed stock and medicine interactions.

9. Liaise with hospitals regarding admitted aged care residents to ensure correct and current medicine profile is available for all hospital staff (GPs, pharmacists, nurses etc.). [Comment from pharmacist: *This is time consuming and is often needed urgently therefore interrupts the work flow*.]

10. Out of stocks: Pharmacy provides alternatives for doctors to ensure patient gets the best health outcomes and make sure there are no interruptions to patient's health regime.

11. Emergency deliveries: Pharmacies required to deliver medicine urgently for patients to ensure there is no interruption to patient's regime. This is commonly done for urgent antibiotics and especially for patients who are palliative and have elected to be at the facility instead of the hospital.

12. Printing of medicine charts and signing sheets on a monthly or when required basis. [Comment from pharmacist: *This cost is borne by the pharmacy not the facility. Not only are there consumables costs involved but also staff time*.]

13. Examples of where pharmacist intervention has directly benefited the patient:
    - GP charts PRN paracetamol. Pharmacists detects that patient is already using max dose of paracetamol regularly. Contact made with GP and facility. Overdose and potential hospitalisation avoided.
    - Monthly generation and review of psychotropic medicine use within aged care facility. This enables pharmacist to alert facility and GP of continued use and allows for a review and potential cessation or reduction in psychotropic medicine.

List of activities needed to be undertaken by the pharmacy when RACF admits a new resident

- Obtain resident's details (this may need to be followed up with a call to Medicare to ensure correct entitlements) - directly impacts the cost of medicines to the resident.
- Obtain medication chart and/or prescriptions from RACF, GP, patient or family.
- Conduct medication reconciliation to confirm current medicine list.
- Clinical review of medicines profile (this is the stage where interactions, allergies, over/under dosages, correct medicine based on diagnosis are reviewed and determined to be correct or incorrect). If discrepancies are found, a call to the GP is made.
  [Comment from pharmacist: *This is more pharmacist time that is not remunerated*.]
- Enter medicine profile into DAA software.
- Dispense medicine
- Pack the medicine in DAA.
- Check that the DAA is correct and corresponds to the current medicine profile of that resident.
- Print signing sheets.
- Invoice patient via agreed billing process
- Deliver the medicine to the facility.

3.2 Residential Medication Management Reviews (RMMRs) and Quality Use of Medicines (QUM)

The RMMR Program, including QUM, is one of the Medication Management Programs funded under the Sixth Community Pharmacy Agreement to support quality use of medicines services that are designed to reduce adverse events and associated hospital admissions or medical presentations.

RMMRs are designed to enhance the quality use of medicines for residents in approved Australian Government funded aged care facilities, by assisting residents and their carers to better manage their medicines. The program also supports activities that are designed to improve quality use of medicines across approved Australian Government funded aged care facilities through the QUM component of the program.[7]

3.2.1 Residential Medication Management Review (RMMR)

RMMR is a service provided to a permanent resident of an Australian Government funded aged care facility, following a confirmation by the resident's GP that there is an identifiable clinical need that the patient will benefit from a RMMR service. It is conducted by an accredited pharmacist when requested by a resident's general practitioner (GP) and undertaken in collaboration with the resident's GP and appropriate members of their healthcare team. A comprehensive assessment is undertaken to identify, resolve and prevent medicine-related problems and is provided to the resident's GP.

Residents in flexible care arrangements and transitional care facilities are also eligible for RMMRs.

An approved RMMR service provider means:

- the owner of an approved Section 90 pharmacy; or
- a business entity, (including an accredited pharmacist operating as a sole trader); and
- holds a current RMMR Service Agreement with a RACF

Frequency of service

One RMMR Service can be conducted per eligible patient on referral from a GP. A subsequent RMMR service may be conducted if more than 24 months has elapsed since the date of the most recent patient interview, or when the patient's GP specifically deems a subsequent review is clinically necessary, such as when there has been significant change to the patient's condition or medicine regimen.

Reasons why an additional review may be requested include:

- Discharge from hospital after an unplanned admission in the previous four weeks;
- Significant change to medicine regimen in the past three months;
- Change in medical condition or abilities (including falls, cognition, physical function);
- Prescription of a medicine with a narrow therapeutic index or requiring therapeutic monitoring;
- Presentation of symptoms suggestive of an adverse drug reaction;
- Sub-therapeutic response to therapy; or
- Suspected non-compliance or problems with managing medicine related devices.

[7] http://6cpa.com.au/medication-management-programs/residential-medication-management-review/

3.2.2 The QUM service

The QUM service is a separate service provided by a registered or accredited pharmacist and focuses on improving practices and procedures as they relate to the quality use of medicines in a residential care facility.

An approved QUM service provider means:

- the owner of an approved Section 90 pharmacy; or
- a business entity, (including an accredited pharmacist operating as a sole trader); and
- holds a current valid QUM Service Agreement with a RACF.

The type and frequency

The type and frequency of QUM services are documented within the service agreement between the service provider and the facility.

QUM Services for which the provider may be entitled to remuneration from the 6CPA are as follows.

Medication Advisory Activities

- Participate in drug usage evaluation (DUE).
- Advise members of the healthcare team on a range of issues, including storage, administration, dose forms, compatibilities, therapeutic and adverse effects and compliance.
- Participate in Medication Advisory Committees.
- 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.

Education Activities

- 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 RACF or MPS staff, including provision of newsletters.

Continuous Improvement Activities

- 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.
- Advise on and 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.

3.3 Issues/ Challenges

3.3.1 Funding

Earlier sections of this submission outline the various elements of the roles and services provided by community pharmacies to the residential aged care facilities as part of their supply contracts. The Guild now highlights the challenges as reported by community pharmacists.

As described earlier, the contracted pharmacies are required to not only dispense medicines to aged care facilities around Australia but also perform a number of associated pharmaceutical care and related services as part of the supply contract. It has been reported by many pharmacists that the terms of the contracts are one-sided and onerous from many aspects. Apart from the PBS remuneration for dispensed PBS medicines, all other services described earlier (i.e. DAAs, daily deliveries, after-hours access etc) are not funded despite these services to the RACFs being considerably more costly and time-consuming than those provided to community patients.

This financial burden on the community pharmacy undermines the pharmacy's resourcing and capability to best support medicines safety and optimal medication management in RACFs. Any future changes to the current PBS funding policy (e.g. 60-day dual listing) that would decrease the pharmacy's remuneration will impact the overall sustainability and viability of community pharmacies and their ability to continue providing services to RACFs. Pharmacies need to remain viable if they are to provide a safe and high quality service to their local RACF. Therefore, policy decisions by the Government and independent advisory groups such as the Pharmaceutical Benefits Advisory Committee which affect the remuneration of community pharmacy for subsidised products or services should not be made in isolation but with consideration of any flow on effects to the capability of providing other services such as aged care support.

To add to this financial strain on community pharmacy businesses, there is an unfortunate industry trend where aged care organisations expect and require pharmacy contractors to provide additional and unremunerated components and services such as medicine trolleys, software programs and medicines information and education activities (not funded through QUM services).

Consequently, this situation of having to cater to the increasing demands has resulted in pharmacies needing to scale their operations and introduce process-based efficiencies to remain viable. When this is not achievable, it results in many local pharmacies discontinuing their contracts with the facilities in their local areas.

Many Guild members have reported that a number of larger volume pharmacy providers have risen to market dominance, resulting in a shift in the nature of service provision with many cases of the dispensing pharmacy being from outside of town rather than the local area supporting patients' choice and established relationships.

The Guild's geospatial analysis[8].indicates that:

- 99% of residential aged care facilities have access to at least one community pharmacy within 2.5 km radius in metropolitan areas and 93% in regional areas
- 78% of residential facilities across Australia have access to at least two pharmacies within 2.5 km radius; and
- 80% of residential facilities have access to at least three pharmacies within 10 km radius.

Therefore, the local community pharmacy should be the first preference to support efficiencies with timely access and continuity of care.

[8] Geospatial analysis 2019, the Pharmacy Guild of Australia

There are also many reports that patients are asked to have their medicines dispensed from the facility's preferred supplier although they have expressed a wish to stay with their local community pharmacy. This is despite the fact a patient's right to choose is stipulated in the *Aged Care Act 1997*[9]. The *Guiding Principles for medication management in residential aged care facilities*[10] also states *"Assessment of a resident's suitability for a DAA should also take into account the person's rights, such as choice of pharmacy service, and any costs associated with obtaining his or her medicines in DAAs. Regular medication reviews should reassess the continuing requirement for use of DAAs by the resident."*

Many pharmacists have reported that despite not having the supply contract, they often are contacted by the local RACF to deliver emergency medicines during the day as well as after hours. Unfortunately, this leads to fragmentation of care and compromises the sustainability of community pharmacy as a partner to aged care providers.

Aged care funding model – consideration of 'true total cost'

Significant reform is required around the community pharmacy and aged care interface to deliver greater support to patients and aged care organisations. This reform should relate to funding (better use of existing as well as increased total funding) and appropriate application and monitoring of practice standards and procurement guidelines.

The existing arrangements mask these significant hidden costs and do not adequately remunerate the contracted community pharmacy in providing professional services in the RACF.

Recommendations (1-6):

1. Funds for medicine management services in RACFs should be reformed to ensure all pharmaceutical care is provided through facility based community pharmacy aged care package.

2. The Aged Care Funding Instrument (ACFI) and other direct-to-provider funds should be reviewed to ensure their efficiency is maximised within the current system including payment for comprehensive medicines management systems (DAAs) quarantined to support RACF to administer.

3. Funding model solutions and procurement reform must involve consideration of the 'true total costs' – be it time taken for community pharmacies to deliver services, communicate, resource materials or the cost of infrastructure to ensure viability.

4. The Government and independent advisory groups such as the Pharmaceutical Benefits Advisory Committee must ensure that policy decisions which affect the remuneration of community pharmacy for subsidised products or services are not considered in isolation but with consideration of any flow on effects to the capability of providing other services such as aged care support.

[9] https://www.legislation.gov.au/Details/C2019C00199/Download
Division 2-1 (g) to encourage diverse, flexible and responsive aged care services that:
(i) are appropriate to meet the needs of the recipients of those services and the carers of those recipients; and (ii) facilitate the independence of, and choice available to, those recipients and carers.

[10] https://www1.health.gov.au/internet/main/publishing.nsf/Content/EEA5B39AA0A63F18CA257BF0001DAE08/$File/Guiding%20principles%20for%20medication%20management%20in%20residential%20aged%20care%20facilities.pdf

5. Procurement and tendering guidelines should be developed so that key service requirements are not compromised over other indirect 'value add' components e.g. paying for drug trolleys or IT systems.

6. The local community pharmacy should be used as a first preference to support efficiencies with timely access and continuity of care, given that 99% of residential aged care facilities have access to at least one community pharmacy within 2.5 km radius in metropolitan areas and 93% in regional areas, 78% of facilities across Australia have access to at least two pharmacies within 2.5 km radius and 80% of facilities have access to at least three pharmacies within 10 km radius.

3.2.2 RMMRs and QUM

An essential component for quality of care is point of care access to appropriate health professionals.

Many health professionals find it difficult to identify the most appropriate mechanism to fund the level of on-site patient care they feel necessary and are hindered by significant red-tape and limitations around the rules through which they can engage in care.

Referrals for RMMRs should be able to be initiated by any clinician involved in the patient's care. Often the GP sees the patient only when they are acutely unwell. Nursing staff and care providers see the patient daily and can identify issues and concerns with medicines and should be able to refer for a full medicine review according to criteria such as deterioration of the patient's condition or adverse effects.

Pharmacists, as health professionals with expertise in medicine management, have the skills and knowledge that, under the right framework, will significantly reduce the risk of medicine associated harm, and improve health outcomes and quality of life for individuals. This requires an adequately structured, governed and efficiently funded clinical (point of care) program into aged care environments that would address gaps and improve overall health benefits to residents.

There has been some misinformation that RACFs would have to have an independent consultant pharmacy service provide RMMRs and QUM services separate to their preferred supplier of medicines. Guild members have been informed by local facilities that "other managers of homes have all stated that they have separate RMMR and QUM services separate to the pharmacy supply medicine" and that their QUM contract would be terminated. They have cited the requirements of the new Aged Care Quality Standards that came into effect in May 2019[11] although the document does not specifically mention the requirement to separate these activities, only that there must be effective policies and procedures to support safe use of medicines[12].

There have been other commentaries from independent businesses that the dispensing pharmacy should not do RMMR or QUM although the reasoning is not clear, or evidence based.

The Guild strongly believes that the dispensing pharmacy should ideally hold both contracts and only outsource as a third party contract if it does not have the workforce to deliver this. A holistic and integrated approach to the clinical care of residents by a consistent provider would create efficiencies, reduce costs and ensure continuity of care. It makes good clinical sense to have the dispensing and QUM activities linked to the same pharmacy as there are many overlapping or co-dependent processes in the medicine management pathway.

[11] https://www.agedcarequality.gov.au/sites/default/files/media/Aged%20Care%20Quality%20Standards.pdf 2019
[12] https://www.agedcarequality.gov.au/providers/standards/standard-3/standard-3-3-b

Residents should have the ability to establish a trusted relationship with a regular pharmacist, rather than with a fly in/fly out pharmacist, often from another State. In rural and remote towns, the local pharmacist is a trusted member of the healthcare team. Rural pharmacists are ideally placed to provide services to local residential aged care facilities. A clinical governance framework should ensure policies and procedures are implemented to support the safe use of medicines.

These issues can be addressed by the implementation of the facility based pharmacy aged care package outlined in section 3.4.

Recommendations (7-10)

7. The Aged Care Quality Standards should reflect the integral nature of dispensing of medicines and QUM functions to ensure holistic patient care.

8. Local community pharmacies, GPs and other health practitioners should be encouraged to service local facilities in their community.

9. RACF clinical governance frameworks should include a clinical advisory committee consisting of a GP, community pharmacist, allied health professional and consumer representative, with authority to advise on the safety and quality of clinical care, including medicine management.

10. Due to the complexity, inefficiencies, fragmentation and costs of RMMR/QUM programs, these services should be replaced with a more holistic and flexible funding model through facility based pharmacy aged care package which is based on clinical need.

Medicines dispensing management workflow

As mentioned in the previous section, the current continuum of medicine dispensing involves a complicated workflow with a myriad of options for implementation. The medicine is ordered by a GP on a prescription or national residential medicine chart (NRMC), then dispensed by the pharmacist and claimed on the Pharmaceutical Benefits Scheme (PBS).

Currently Controlled Drugs (Schedule 8) and Authority-Required PBS items cannot be supplied from a NRMC and hence a separate prescription is required for them to be supplied on the PBS. Once supplied to the RACF, medicines are administered to the residents by staff at which point the staff need to record the administration of this medicine on the chart.

The practice of GPs having to issue traditional prescriptions for all of their RACF patients is still common. This means double handling for both GPs and pharmacists in the supply chain, with pharmacist dispensing GP's orders to supply medicines and 'marking off' (virtually re-dispensing medicine) when the prescription is provided by the GP. This results in the administrative burden faced by them doing work two to three times on multiple systems to service the RACFs.

The options for RACF staff to record administration of medicines are also varied. Signing for medicine may occur on the original chart, on signing sheets provided by the pharmacy, or on a digital platform facilitated by the pharmacy.

Further, the current system does not provide for special circumstances of dispensing a medicine without a legal prescription and often these medicines are required urgently and are therefore not able to be provided in a timely manner. The pharmacy is then presented with the dilemma of either providing the medicine to ensure ongoing care or withholding the medicine that is 'charted' because it does not have the legal prescription available to an enable timely dispensing of the medicine.

Additionally, the pharmacy is also placed at a financial disadvantage as the legal prescription to claim from Medicare PBS has not been written and presented, even though the medicine is charted for the resident therefore 'technically' representing an order to administer the medicine(s).

The Guild supports digital health enablement through solutions that improve service workflow, QUM and patient safety. A common practice in RACF medicine supply is the notification of changes to a resident's medicine regimen to the pharmacy via email or fax. Occasionally, faxes may not be received for various reasons which means that medicine is not supplied in a timely fashion or not supplied at all, resulting in the patient not receiving the right medicine at the right time.

Digital medicine charting will also address 'pain points' for both prescribers and the RACF-contracted community pharmacy. Currently there are trials with a small number of providers in New South Wales and South Australia with a new electronic charting system that will streamline the process from the prescribing through dispensing to administering to the patient.

To further support consistency of medicine management service delivery, system interoperability must be pursued. In the healthcare sector, particularly in transitional care, it is vital for data to be shared, and then clearly articulated and understood once it is received. Interoperability is a concept that many RACF system providers need to prioritise and this needs to be supported by government and the respective government agencies (e.g. Australian Digital Health Agency) and approached at an industry-wide, governance level.

Recommendations (11-13)

11. The dispensing of all medicines in RACFs should be via the mandatory use of a standardised NRMC in a digital prescribing platform.

12. A real time notification of medicine changes for RACF staff and the supply in contract pharmacy should be integral to the digital NRMC. This single digital platform for all medicine-related matters would provide efficiencies enabling all professionals in the medicine management pathway to better use their skills to improve patient outcomes.

13. Legislative change is required to allow prescribers and pharmacists to prescribe and dispense all medicines from a NRMC, including Schedule 8 medicines, PBS authority required items requiring prior approval, and S100 Highly Specialised Drugs.

ICT and system software synergy

Often a RACF will choose a medicine management software platform that works well with the contracted community pharmacy or, in other cases, the pharmacy will have to invest in new software to service the RACF. Additionally, when the resident chooses a pharmacy provider that does not have the compatible software with the RACF system, this can present issues resulting in the medicine management for that resident potentially being compromised by variation and inconsistency with procedures around the charting, signing, supplying, packing and administration of that resident's medicine.

Recommendation (14)

14. All pharmacy based medicine management software platforms should be consistent and conformant for charting, signing, supplying, packing and administration of medicines to ensure the resident's medicine management is optimised.

3.2.3 Use of psychotropic medicines as chemical restraint

As outlined in a recent article in The Medical Journal of Australia by Juanita Westbury et al[13] "*The known inappropriately high rates of psychotropic prescribing in Australian residential aged care facilities (RACFs) have been reported for several decades despite media and political attention and guidelines for reducing use".* Their study showed that the RedUSe program, a multi-strategic interdisciplinary program, implemented in 150 RACFs achieved significant reductions in antipsychotic and benzodiazepine prescribing without substitution by other psychotropic agents. Targeted interventions can reduce over-reliance on psychotropic medication for managing mental and psychological symptoms of RACF residents. The authors recommended the RedUSe intervention should be made available to all Australian RACFs to reduce the inappropriate prescribing of psychotropic medications.

The Guild supports such initiatives as RedUSe and we would recommend formalising the pharmacist as the 'leader' of medicine management and QUM in RACFs. Pharmacists should be able to practise to their full scope and autonomously prescribe to improve medicines access and management per the Guild's submission to the Pharmacy Board of Australia on pharmacist prescribing, which outlines successful models from international experience.[14]

If pharmacists were given prescribing rights this would also give them the right to deprescribe medicines which would assist in addressing the inappropriate use of antipsychotic and benzodiazepines medications in RACFs. It would also provide timely access to medicines in times of urgent need.

Recommendation (15)

15. Pharmacists should be provided with autonomous prescribing rights as this will give pharmacists the right to deprescribe and prescribe medicines for patients in RACFs in a timely manner. This will address issues of chemical restraints and provide timely access to medicines in times of urgent need.

[13] https://www.mja.com.au/journal/2018/208/9/reduse-reducing-antipsychotic-and-benzodiazepine-prescribing-residential-aged

[14] Guild submission to the Pharmacy Board of Australia on pharmacist prescribing https://www.pharmacyboard.gov.au/documents/default.aspx?record=WD19%2f28661&dbid=AP&chksum=q1PpNlpKnx3V8DhYph%2fmfw%3d%3d

3.4 Embedding non-dispensing pharmacists in aged care facilities is duplication of care

The Guild does not agree with the position advocated by other pharmacy organisations such as Pharmaceutical Society of Australia (PSA), and a handful of Primary Health Networks (PHNs) to embed pharmacists in residential aged care facilities.

The Guild does not support further fragmentation of care by the proposal of embedding pharmacists into RACFs as this could be clinically inappropriate. The service roles should not be duplicated, and patient care must not be fragmented by employment of independent pharmacists. The emphasis should be on the importance of not duplicating services or roles but using the available workforce in community pharmacy to increase integration of pharmacists into the other areas of the healthcare team, especially in areas with limited health workforce.

Community pharmacy is an integral part of the primary healthcare system and collaboration between community pharmacy and all healthcare services provides integrated patient-centred care improving the quality use of medicine.

The current medicine management system is fragmented and inefficient. This fragmentation of care can negatively affect the quality of service, medicine management, and continuity of care provided to residents. It increases the possibility of medicine misadventure, places the residents' health at risk and compromises the quality use of medicines.

Currently, the Guild understands that the majority of medicine management services, such as Residential Medication Management Reviews (RMMRs) and Quality Use of Medicines (QUM) services are held by a small number of providers, resulting in many aged care facilities being serviced by fly-in/fly-out providers rather than by the local community pharmacy. In addition, suppliers that are not based in the same town as the facility are providing many medicine supply contracts. In these situations, the supplier does not provide urgent medicine support or advice and as such, the facility commonly relies on the local pharmacy to fill this gap.

Medicine management activities are undertaken by pharmacists in collaboration with aged care staff. Currently Residential Aged Care Facilities may have arrangements in place with up to four different pharmacy service providers for various functions. Under the current arrangements, many of these services are corporatised and delivered remotely.

The key is to strengthen the connection between local community pharmacies and the aged care facilities.

For pharmacists to be most effective within an aged care facility at maximum efficiency to the health system, they must maintain and strengthen the patient's relationship with their community pharmacy, and ensure efficient use of limited health funding by not duplicating services already being provided in the local community pharmacies.

Due to the current shortage as well as mal-distribution of the pharmacy workforce, particularly in rural and remote Australia, the Guild is concerned that the employment of pharmacists in RACFs will exacerbate existing workforce pressures and the sustainability of the community pharmacy network. Moreover, it is an inefficient use of government funds and not cost effective to embed pharmacists in RACF and duplicate services that can be provided by community pharmacy in a more timely manner including access to a pharmacist after hours for urgent needs.

In rural and remote areas, embedded independently contracted or employed pharmacists would not be viable. Community pharmacies in remote or very remote Australia have developed exceptional collaborative models with other local health professionals. They have often cared for these patients for many years and have strong community relationships with family members. They are best suited to provide enhanced models of care and ensure existing relationships are built on and the medication management service is reliable, suitably staffed and consistent with the whole of community care already offered.

The Guild believes that the best way to integrate community pharmacy with RACFs is through an outreach model of care using local community pharmacists.

With appropriate funding, community pharmacy could provide an individualised facility based pharmacy Aged Care Package to support our older Australians living in aged care facilities, which could include:

- A routine, medicine service
  A service dedicated to meeting the medicine management needs of residents, including activities such as medicine delivery and individual medicine counseling provided by a pharmacist at the facility.

- Access to urgent medicines when it is needed
  An emergency or after-hours service to cover urgent circumstances such as post-hospital discharge, an urgent new medicine or change to their medicine regimen, and for palliative care.

- Medicine management system
  Provision of a comprehensive medicine management system to assist residents and facility staff to administer and support adherence to medicines.

- Support older Australians that want to self-manage their medicines
  Assessment, support and regular close monitoring of residents who are able to self-manage their medicines if they choose to, giving them ownership of their medicine management and their health.

- Participate and contribute to relevant case conferencing
  Pharmacist participation and contribution to case conferencing with prescribers, nursing staff, other healthcare professionals, residents and families.

- Provision of medicine reconciliation services to every older Australian
  Development of a Pharmacist Shared Medicines List (PSML) created by the pharmacist on initial consultation as part of the Package, on admission or readmission to the facility, and updated as necessary following changes to medicine regimens

- Provision of medicine reviews based on clinical need
  Access to a community pharmacist to review their medicines when they need it, where they need it, without unnecessary barriers to access. As part of the Package, medicine reviews can occur according to the clinical need of the resident. Clinical need may include post-hospital discharge, following a significant medical event, when there is risk of medicine misadventure, when inappropriate prescribing is suspected or evidence suggestive of errors, or when there is a concern with high-risk medicine prescribing such as benzodiazepines or antipsychotics.

- Whole of Residential Aged Care Facility clinical audits
  Provision of whole of Residential Aged Care Facility review Drug Usage Evaluations (DUE) or clinical audits to improve the quality use of medicines of residents, such as antimicrobial stewardship, psychotropic prescribing, and optimal pain management.

- Participation and contribution to relevant Aged Care Facility committees
  Actively participate and contribute to relevant Residential Aged Care Facility committees such as the Medication Advisory Committee, or Clinical Governance Committee.

- Assistance to dispose of unwanted medicines
  Collection and disposal of unwanted medicines in accordance with regulations and guidelines.

- Management of medicines at Residential Aged Care Facilities
  Assist with the storage and management of residents' medicines and imprest medicines, ensuring that stock levels are appropriate to meet residents' needs, are in date and stored in appropriate conditions including cold chain management, managing and reconciling Schedule 8 Controlled Drugs safe and Controlled Drugs destruction and dispose of out of date medicines in accordance with regulations. The community pharmacist can develop and implement pharmacist-initiated medicines lists, including pharmacist prescribing such as antibiotics and schedule 3 medicines.

This will ensure closer collaboration between community pharmacy and RACFs, achievable by enhanced communication and information technology such as secure messaging systems, shared care planning and tele-medicine.

ACT Goodwin trial published papers plus current ACT PHN funded trial of embedding pharmacist in 27 RACFs in the ACT.

The Guild agrees that pharmacists are a vital resource in ensuring the safety and quality of services provided to aged care residents, specifically medicine management services. The Guild notes that the literature supporting the ACT trial at Goodwin residential care facility shows that it makes sense to integrate pharmacists as part of the care team, more so than is currently the case.

However, the Guild is concerned that the trial protocol for the pilot study did not include the role of the dispensing pharmacist. The Guild understands the ACT PHN (Capital Health Network) has received funding in the Federal Budget 2019 to support a Canberra trial to embed a part-time pharmacist in all 27 RACFs to ensure quality use of medicines.

Given that the community pharmacy network already works with RACFs in the ACT by providing medicine supplies, the Guild would like to ensure the trial partners with community pharmacy in the design and implementation to ensure that it can provide the best possible research into the provision of care to residents in RACFs, and not have unintended consequences to the community pharmacy network.

As mentioned above, the relationship between a community pharmacy and RACF is not just a medicines supply role, and the pharmacist responsible for the dispensing and supply of medicines has professional responsibilities to clinically review a resident's medications at various points, including when first admitted to a facility, on discharge from hospital, or when there is any change to prescribed medicines. Community pharmacists are constantly communicating with facilities to manage medication problems, yet this is often done offsite due to the current model of care.

There has been no research comparing the 'embedded pharmacist in RACFs' model and the 'Community Pharmacist Outreach' model. Therefore, these trials should assess the cost-effectiveness, economic benefit and outcomes from a patient, and workforce perspective on various options.

In this context the Guild would like to share the feedback that it received from one of its members from a rural area who services the RACFs.

The issues raised in these published papers are due to poor enforcement of standard elements of what should form the basis of a RACF/supply pharmacy contract and RACF/QUM supplier contract.

- I have concerns over 'onsite clinical pharmacists' only being available two days per week, disrupting the continuity of care the supply pharmacy is currently an integral partner in.

- The current 'logistical difficulties and access restrictions' associated with RMMR pharmacists is due to the aged care sector citing 'best practice' to have the supply and RMMR pharmacy being different providers. This results in the QUM/RMMR contract going to external companies, the quality of the RMMRs is poor and their professional relationships with local GPs is not much different.

- Transition-related medication errors is an area the Local Health Districts need to urgently address; having a residential care pharmacist will not address this issue, there needs to be a discharge coordinating pharmacist who liaises with the supply pharmacy. It does not make sense to have a 15 hour per week residential care pharmacist when most discharges take place outside of normal business hours and the supply pharmacy is key to this process.

- The majority of the outcomes they are looking to achieve are currently being met by professional community pharmacy operators, supplying a service which the aged care sector needs - not pharmacies with zero weekend or after hours services.

- In 2018, the pharmacy was contracted to supply vaccination services for RACF staff at one of our facilities. We achieved rates equal to, if not better than, those cited in the paper. It is about meeting the needs of the RACF and staff.

- They are citing an 'as required' model for the RCP, two days per week does not meet the need of this...the supply pharmacy does. If not, review the supply contract!

- 15 hours per week is not likely to overlap with the majority of GP visits to RACFs, most in the country visit after hours or weekends and liaise with the supply pharmacy.

- Pharmacy currently provides medicine related training and dosage form modification guidance as part of our supply contract.

- Perhaps the government needs to consider mandatory vaccination rates as policy and part of accreditation to protect our vulnerable RACF patients?

- Community pharmacies are well placed to address the 'holes in the Swiss cheese', the funding simply requires redirection and clear guidelines on outcomes.

Recommendations (16-17)

16. The government-funded trials of embedding pharmacists in residential aged care facilities should assess the cost-effectiveness, economic benefit and outcomes from a patient, and workforce perspective on various options including a comparison with a community pharmacy outreach model.

17. The service roles should not be duplicated, and patient care must not be fragmented by employment of embedded pharmacists. The best way to integrate community pharmacy with RACFs is by an outreach program using local community pharmacists via a facility based pharmacy aged care package.

4. PHARMACY AS COMMUNITY-BASED AND PRIMARY HEALTH CARE AGED CARE SUPPORT SYSTEM

Community pharmacies are well aware of the requirements of older Australians; providing and facilitating support services and longer-term strategies to assist older Australians to continue to live independently in their community for as long as possible. This support also extends to carers, particularly in the instance of dementia and/or palliation where a carer is primarily responsible for medicines administration and healthcare decisions.

There is a need for Government to recommend policies, systems and funding arrangements that aim to support older Australians to live independently in the community for as long as possible before needing to move to residential aged care facilities or palliative care.

4.1 Continence care

Incontinence is a condition that is surprisingly common and the Continence Foundation of Australia estimates that in Australia alone, more than 6 million people have bladder or bowel control problems for a variety of reasons[15]

During 2007-2010, the Guild conducted a national project 'the Pharmacy Continence Care Program (PCCP)' funded by the then Department of Health and Ageing as part of the Government's National Continence Management Strategy (NCMS). The project aimed to raise community awareness of incontinence and to recognise and promote help-seeking strategies by consumers through community pharmacists and pharmacy staff.

The evaluation of the program concluded that the PCCP contributed to achieve the objectives of the NCMS through the promotion of bladder and bowel health across the lifespan; increasing awareness of bladder and bowel health within the population; and improving access to quality continence care. Therefore, the Guild recommends a wider national roll out of similar programs to be made available.

[15] https://www.continence.org.au/pages/what-is-incontinence.html

Community pharmacies have a range of products and services to help manage incontinence and pharmacy staff are trained to help select the most appropriate treatment for individual needs. Private counselling rooms are often available when discussing the condition.

Continence management is one area where community pharmacy is actively involved in working with other health professionals to identify, advise, refer and promote continence awareness to people with, or at risk of, incontinence. Therefore, the Guild recommends a wider national roll out of similar programs to be made available.

Recommendation (18)

18. Consideration should be given to funding the pharmacy continence care services that promote bladder and bowel health across the lifespan and improve access to quality continence care.

4.2 Dementia care

Dementia is the second leading cause of death of Australians. In 2017, dementia remained the first leading cause of death of women, and the third leading cause of death of men. In 2019, there are an estimated 447,115 Australians living with dementia. Without a medical breakthrough, the number of people with dementia is expected to increase to 589,807 by 2028 and 1,076,129 by 2058.[16]

Despite the comparatively high prevalence of people living with dementia in aged care facilities, the majority of people living with dementia do so in the community. In 2018, people living in the community accounted for 70 per cent of those living with dementia in Australia.

The rising prevalence of dementia, both as a leading cause of death and burden of disease is witnessed by community pharmacies daily, as they work to support patients and carers to manage this condition.

As community pharmacists see patients during the period of early cognitive decline, they are well-positioned to detect early signs and provide a point of triage and support to the patient's transition to further primary and specialist care.

Community pharmacies support people with dementia to remain in their homes longer, by providing ongoing medicine management services including medicine reviews, DAAs and other supportive aids for daily living, and, importantly, by also supporting carers of people living with dementia. There are a number of community pharmacies now specialising in dementia care and there would be significant value in studying and, where appropriate, replicating these models of care across the community pharmacy network.

Community pharmacies can also play a role in the early identification of the abuse of the elderly as they are often the most frequently visited health destination by older Australians. With appropriate training would be able to identify the signs of elderly abuse and feel confident in taking the most appropriate action. This training could be included as part of the broader training to enable pharmacies to become dementia friendly health destinations.

[16] https://www.dementia.org.au/statistics

Dementia-friendly pharmacies

The relationship between the patient's carer and the pharmacist is important, in terms of the quality use of medicines and communicating issues requiring referral to the GP or allied health professionals. Dementia-friendly pharmacies are welcoming and understanding of the needs of people who may be suffering from cognitive decline as well as the needs of their carers. These needs include medicine packing, providing timely medicine reviews (particularly after a patient is prescribed an anti-psychotic medicine), identifying significant cognitive and behavioural changes or deterioration and recognising that patients with dementia are likely to suffer from a range of other chronic health conditions.

Recommendations (19-23)

19. Community pharmacy should be used to optimise access to early intervention and referral for the diagnosis of dementia, including to people living in rural and regional areas.

20. The implementation of a dementia-specific, collaborative model of care for the person with dementia, supported by a medicine management plan that is agreed to by the collaborative team i.e. the GP, the community pharmacy, the patient and, if needed, the patient's carer. The focus would be to actively encourage and support wellbeing through regular interaction and collaboration with the patient's trusted health professionals.

21. There is significant funding to support GPs to make a more timely diagnosis of dementia, allowing opportunities for early medical and social interventions. However, the funding restricts consumers' access to early intervention activities to general practice only. Consideration should be given to expanding the funding to community pharmacists to give them opportunities for earlier medical and social interventions, as well as playing a vital role in the referral pathway to general practice.

22. Community pharmacy should be included as 'healthcare facility' where a patient can access telehealth and video conference to a specialist at another location. This will help address some of the barriers to accessing healthcare, including dementia-related medical services for patients in rural, regional and outer metropolitan areas.

23. Community pharmacists and pharmacy staff should receive training to help them identify the signs of elderly abuse. This training could be included as part of the broader training to enable pharmacies to become dementia friendly health destinations.

4.3 Palliative Care

Approximately 70% to 80% of patients receive palliative care in their home. Community pharmacists understand the special needs of those receiving palliative care and the need to provide and facilitate support services. They are also able to assist in providing such care within the home for as long as possible before needing to move to specialised facilities.

Community pharmacists come into regular contact with people in need of palliative care, and will have ongoing communication with their carers, GPs and other health practitioners while they are receiving palliative care in the community. Often they have cared for the patient throughout their illness, and have existing relationships with carers and family. Quality of care is enhanced when patients can be treated by a team that comprises a variety of health professionals, each with their own set of knowledge, skills and experience.

Medicines are an essential component of care for those receiving palliative care, many of whom will be on complicated medicine regimens that often have side effects and potential interactions with other medicines. The medicine management services which support QUM are provided by community pharmacists in the community and residential facilities. These services reduce the number of adverse events by assisting patients and their carers to better manage their medicines.

Community pharmacists can make valuable contributions in the provision of palliative care to terminally ill patients by assisting in appropriate pain and symptom control. Many patients' medicine use may deviate from that prescribed, and they may also use complementary medicine, of which the prescriber may be unaware. Patients with chronic pain may be in need of a higher level of medicine management because of a greater difficulty to obtain pain relief due to tolerance, or the greater potential for adverse effects and interactions between medicines, therefore requiring dose adjustments or alternative therapeutic options.

A palliative care patient's clinical outcome will benefit from management by a multidisciplinary primary care team that involves a community pharmacist with autonomous prescribing rights. A pharmacist with autonomous prescribing rights would assist in providing responsive care and timely access to essential end of life medicines in times of urgent need.

4.3.1 Support to a person requiring palliation at home that community pharmacy can provide

Community pharmacists can undertake the following roles within a multidisciplinary team to assist patients requiring palliative care to remain in the home and receive the best care possible.

- Provide medicine management systems to facilitate better management of medicines
- Undertake medicines reviews
- Provide compounded medicines to address individual problems the patient may have with manufactured medicines such as swallowing difficulties or allergies to excipients;
- Pharmaceutical planning as part of a multidisciplinary team, for example, ensuring the pharmacy has realistic stock-holdings of required medicines, preparation for after-hours and/or unusual requests, advise on interim options where there are difficulties in immediate supply, cost-affordable therapies (e.g. PBS coverage and/or alternatives), regional regulatory requirements, and off-label medicines;
- Identify and address common adverse effects of palliative care medicines, such as nausea, vomiting and constipation, and provide modern wound care treatment;
- Provide medicine information for health professionals, for example, opioid conversions, compatibility advice for medicines mixed in syringe drivers, whether medicines can be crushed, potential side effects etc.
- Provide aids and equipment - such as oxygen concentrators - to enable people to live safely in their own homes rather than needing institutional care;
- Arrange home delivery of medicines and other pharmacy products to patients in the community who are not able to physically attend pharmacy to pick up their medicines;

- Provide medicine profiles to consumers or their carers who are confused about the medicines;
- Provide locally relevant information on other healthcare services, such as respite;
- Dispose of unused or unrequired medicines, particularly controlled drugs and cytotoxics; and
- Assist with accessing timely replacement of nutritional supplements.

What is required is a formalised approach to the pharmacist's involvement in the patient's care plan to ensure that the person requiring palliative care and members of the palliation team are aware of these services and able to access them.

While the focus of palliative care is on the patient, it is also important to recognise the needs of the patient's family and carers. With frequent attendance at the community pharmacy, the pharmacist is well placed to also monitor and support these people, both during the palliative phase and after the patient's death.

Following is the example of two community pharmacies providing palliative care medicines after hours to people's homes.

Home Based Palliative Care Community Pharmacy Services during After Hours Period Project in the ACT

In November 2017, the ACT PHN - Capital Health Network commenced the *Palliative Care Medications during After Hours Period*[17] initiative in two community pharmacies in Canberra to improve timely access to palliative care medicine. This initiative is funded by the ACT PHN, supported under the Australian Government under the PHN program.

The two participating pharmacies provide access to palliative care medicines after hours for home-based palliative care clients residing in the ACT. However, the medicines can also be delivered at other times to meet patient needs if required. This delivery service also includes residential aged care facilities and healthcare facilities as needed. Extenuating circumstances involving the urgent delivery of Schedule 8 (Controlled Drugs) medicines outside of these after-hours periods are considered on a case-by-case basis. The cost to the patient is a flat fee plus the cost of their medicine. These two pharmacies also deliver continence products and wound dressings as part of the urgent deliveries as needed.

Staff at the participating pharmacies have undergone training in the Program of Excellence in the Palliative Approach (PEPA)[18].

The following recommendations highlight some of the gaps that will need to be addressed to support community pharmacies' role in palliative care services.

[17] https://www.chnact.org.au/after-hours-primary-care-innovation-grants-%E2%80%93-palliative-care-medications-during-after-hours-period
[18] https://pepaeducation.com/workshops/

Recommendations (24-31)

24. There needs to be a recognition of the potential role of a community pharmacist within a multidisciplinary team to assist patients requiring palliative care to remain in their home and receive the best care possible.

25. Consideration should be given to funding a community pharmacist's involvement in structured Care Plan arrangements for palliative care patients and to ensure minimum stock levels of essential palliative care medicines are available.

26. Access to effective palliative care medicines requires consistent legislation between States and Territories to ensure access is not hampered.

27. Relevant agencies should consider how to minimise cross-border barriers and streamline access to essential medicines for palliative care patients.

28. There would be significant benefits to the Government and to the patients and their families to fund DAAs services as part of palliative care services.

29. Funding should be available for pharmacists' visits to a hospice to deliver QUM services for palliative care and pain management as identified by the facility similar to that provided in the UK by the National Health Service.

30. Medicines that are not specifically registered on the Australian Register of Therapeutic Goods (ARTG) for palliation but registered for other uses and indications should be identified, and sponsors of these medicines should be encouraged to update the TGA-approved indications and the list on PBS for palliative care.

31. All palliative care medicines should be PBS listed in the best interest of patients requiring palliative care treatment in the community.

4.4 Reform to home care packages

The growing demand for community-based home care packages reflects the strong preference of older Australians to remain living in their homes for longer. Community pharmacies provide a range of vital medicine-related services to older Australians. There is a wealth of international evidence showing that medicine misadventure and medicines non-adherence are a key cause of unnecessary hospital admissions and readmissions and premature entry into residential aged care.

Recently completed market research conducted for the Guild's *Community Pharmacy 2025* planning project has shown that Australians are highly supportive of community pharmacy delivering a range of in-home services to the ageing, reflecting the high trust and value that the Australian public place in their local community pharmacies.[19]

[19] https://www.guild.org.au/about-us/community-pharmacy-2025

Unfortunately there is little recognition for the importance of medicine management in the various assessment tools and approved service options for home care packages to enable older Australians to continue living independently in the community. This needs to be rectified as a matter of priority.

Community pharmacies are ideally placed to support Australians ageing in their homes and to help lower their cost of care to the broader health system, including those who are most at risk of frequent hospitalisation. Appropriate prioritising and funding for QUM services and initiatives in the community, will ensure that community pharmacies can deliver a high level of care to those older Australians living at home.

The community pharmacy workforce can provide a comprehensive community based pharmacy aged care package to each and every aged Australian tailored to meet their individual and unique medicines needs, supporting them with their medicines as they move through the ageing cycle from in-home care to Residential Aged Care and end of life.

With appropriate funding, community pharmacy could provide an individualised community based aged care package, which could include:

- A routine, medicine service
  A service dedicated to meeting the medicine management needs of the older Australian, such as medicine counselling provided by a community pharmacist in the home, either face to face or using advanced technology such as telehealth solutions. Community pharmacy can provide home delivery of medicines and other pharmacy items for older Australians who have limited mobility or carer availability to assist.

- Access to urgent medicines when it is needed
  To cover urgent circumstances when an older Australian needs it; for example end of life care.

- Medicine management system
  To support older Australians and their families and carers administer and support adherence to medicines through the provision of a comprehensive medicine management system

- Support older Australians that want to self-manage their medicines
  Community pharmacists can assess and provide education, support and regular close monitoring of older Australians who are able to self-manage their medicines if they choose to, to give them ownership of their medicine management. Support may include medicine reminder services and prescription reminder services, home deliveries, and monitoring.

- Participate and contribute to relevant case conferencing and improve access to healthcare, particularly in rural and remote Australia
  Working as part of the collaborative care team with the GP, other health professionals, patient and carer, pharmacists can contribute to case conferencing to prevent hospital admission and re-admission, and reduce adverse medicine events.

- Improve access to healthcare via telehealth services, particularly in rural and remote Australia
  Access to telehealth services will help address some of the barriers to accessing healthcare, including dementia-related medical services, access to specialists and post-hospital follow-up with surgeons, particularly for patients in rural, regional and outer metropolitan areas.
  Community pharmacy can provide older Australians access to telehealth and video conference to a specialist at another location.

- Provision of medicine reconciliation services to every older Australian
  This includes the development of a Pharmacist Shared Medicines List (PSML) created by the pharmacist on the initial consultation as part of the Package, and updated as necessary on an as-needs basis.

- Provision of medicine reviews based on clinical need
  Older Australians must have access to a community pharmacist to review their medicines when they need it, where they need it, without unnecessary barriers to access. As part of the Package, medicine reviews can occur according to the clinical needs of the person, and where best suits them, such as in the pharmacy, or at their home. Clinical needs may include post-hospital discharge, following a significant medical event, when there is risk of medicine misadventure, when inappropriate prescribing is suspected or evidence suggestive of errors, or when there is a high-risk medicine related concern such as prescribing of benzodiazepines or antipsychotics.

- Whole of medical practice clinical audits
  The community pharmacist can provide a whole of medical practice review or audit of prescribing and use of medicines to improve the quality use of medicines in older Australians at the GP practice, and identify, provide education, address and improve the quality use of medicine use such as antimicrobial stewardship, psychotropic prescribing, and optimal pain management.

- Assistance to dispose of unwanted medicines
  Collection and disposal of unwanted medicines in accordance with regulations and guidelines, preventing incidences of medicine misadventure.

Recommendations (32-34)

32. Community based pharmacy aged care package should be implemented to support older Australians to live at home for longer.

33. Medicine management and support should be recognised as an approved core service in home care package.

34. More flexible funding in home care packages to allow for the various scope of services that community pharmacies can offer including:
    - access to local community pharmacist and their clinical expertise
    - medicine management and medicines reconciliation services based on clinical need
    - personalised medicine management plans that are delivered collaboratively (with prescribers and care providers) that can significantly reduce adverse medicine events and hospital admissions and re-admissions; and
    - home delivery of medicines and other pharmacy items for patients who have limited mobility or carer availability to assist including collection and disposal of unwanted medicines accordance with regulations and guidelines, preventing incidences of medicine misadventure.

5. CONCLUSION

It is a challenge to provide adequate, efficient and quality health and aged care services for older Australians due to the increasing proportion of the older population in Australia. Polypharmacy and the alarming rates of medicine-related problems are crucial factors resulting in poor health outcomes, admission to hospital and residential aged care facilities.

Therefore, the Guild supports and recommends policies and systems that:

- promote high-quality health and aged care;
- sustain independence and quality of life;
- support older people to live independently in the community for as long as possible before needing to move to residential aged care facilities; and
- have the potential to reduce admissions to hospital and residential aged care facilities and poor health outcomes due to medicine management issues
- invest taxpayer funds in existing networks to better deliver health outcomes rather than duplicating or fragmenting care

Community pharmacies are ideally placed to support Australians ageing in their homes and in aged care facilities and to help to lower their cost of care to the broader health system, including those who are most at risk of frequent hospitalisation.

The Guild draws the Commission's attention to pharmacists' expert knowledge in medicines and medicines management and the current infrastructure and network of community pharmacy.

Recently completed market research conducted for the Guild's *Community Pharmacy 2025* planning project has shown that Australians are highly supportive of community pharmacy delivering a range of in-home services to the ageing, reflecting the high trust and value that the Australian public place in their local community pharmacies.

Pharmacists, as health professionals with expertise in medicine management, have the skills and knowledge that, under the right framework, will significantly reduce the risk of medicine associated harm, and improve health outcomes and quality of life for aged individuals. This requires an adequately structured, governed and efficiently funded clinical (point of care) program into aged care environments that would address gaps and improve overall health benefits to residents.

Community pharmacy is able to assist in implementing much-needed policies and systems through a range of expanded professional pharmacy services in both community and residential aged care settings.

This would lead to achieving one of the National Health and Hospital Reform Commission's recommendations in its *Final Report: A Healthier Future for All Australians* …. "To redesign health services around people, making sure that people can access the right care in the right setting and to include a 'full service menu' of health and aged care services necessary to meet the needs of the ageing population and the rise of chronic disease".

6. GLOSSARY

ACFI	Aged Care Funding Instrument
ACSQHC	Australian Commission on Safety and Quality in Healthcare
ARTG	Australian Register of Therapeutic Goods
Community Pharmacist	A pharmacist registered by the Pharmacy Board of Australia who practises in or from a community pharmacy
CMI	Consumer Medicine Information
CPA	Community Pharmacy Agreement
DAA	Dose Administration Aids e.g. Webster Paks®, Medico Paks®
DUE	Drug Usage Evaluation
MAC	Medication Advisory Committee
MPS	Multi-Purpose Service
NCMS	National Continence Management Strategy
NDSS	National Diabetes Services Scheme
NRMC	National Residential Medication Chart
PBAC	Pharmaceutical Benefits Advisory Committee
PBS	Pharmaceutical Benefits Scheme
PCCP	Pharmacy Continence Care Program
PEPA	Program of Excellence in the Palliative Approach
PHN	Primary Health Networks
PSA	Pharmaceutical Society of Australia
PSML	Pharmacist Shared Medicines List
QCPP	Quality Care Pharmacy Program
QUM	Quality Use of Medicines
RACF	Residential Aged Care Facility
RMMR	Residential Medication Management Review
RPBS	Repatriation Pharmaceutical Benefits Scheme
TGA	Therapeutic Goods Administration