Guidelines for pharmacists providing Residential Medication Management Review (RMMR) and Quality Use of Medicines (QUM) services

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GUIDELINES FOR PHARMACISTS PROVIDING RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR) AND QUALITY USE OF MEDICINES (QUM) SERVICES

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1. About the document

1.1 Introduction

Pharmacists play a pivotal role in improving resident health outcomes in aged care facilities (ACF) through the provision of medication review services and quality use of medicines (QUM) services. Communication and collaboration with relevant health care providers and the development, implementation and monitoring of models of good pharmaceutical practice are all essential to this process.

Pharmacists providing services to ACFs focus on two broad areas:

- resident-focussed activities, such as Residential Medication Management Reviews (RMMR), aim to ensure that residents are receiving appropriate drug therapy and monitoring; and
- QUM facility-focussed services such as implementing and monitoring policies, activities for the safe and effective prescribing and administration of medicines. QUM services assist the facility in providing optimum care to all residents, as well as supporting appropriate medicine use processes.

A RMMR service is a comprehensive medication review, by an accredited pharmacist, that is resident-focussed involving a systematic evaluation of the resident's complete medication regimen and management of that medicine. A RMMR aims to optimise the benefits of medicine use, improve therapeutic outcomes for the resident and ensure the judicious, appropriate, safe and effective use of medicines.[1]

A QUM service is separate to a RMMR service and has a focus on improving practices and procedures as they relate to quality use of medicines in an ACF. QUM services cover areas such as medication advisory activities, education and continuous improvement.

Successful medication management services rely on:

- a strong culture of appropriate information sharing;
- the establishment of trust between parties;
- regular face-to-face interactions; and
- a commitment to teamwork and collaboration.

1.2 Background

Since the Second Community Pharmacy Agreement in 1997, pharmacists have been remunerated by the Commonwealth (via Medicare Australia) for the provision of medication management reviews for residents of ACFs. Subsequent agreements have extended these arrangements, promoting greater collaboration between health care providers.

The RMMR initiative arose from recommendations of the National Preventative Health Strategy Report[2] and published studies regarding medication misadventure in residents of

ACFs. These studies demonstrated the incidence of such medication misadventure could be attributed to generally poor health status, high use of medicines, polypharmacy and extensive prescribing of psychotropic medicines among this population.[3,4] Such reports recommended strategies including regular medication reviews, the establishment of Medication Advisory Committees (MAC) and regular nurse education to support appropriate prescribing and medicine use.

The QUM section of Australia's National Medicines Policy considers all medicines should be used safely and effectively, selecting management options wisely and choosing suitable medicines if a medicine is considered necessary.[5] QUM activities and systematic approaches to medication review processes are actively supported by the Australian Government through the development of the *Guiding principles to achieve continuity in medication management* by the Australian Pharmaceutical Advisory Committee (now the National Medicines Policy Committee). These principles aim to achieve continuity in medication management as residents move from one episode of health care to another.[6] In addition, the literature on medication reviews provides evidence of improved health outcomes associated with such services in ACFs.[7]

1.3 Purpose

These Guidelines have been developed by the Pharmaceutical Society of Australia (PSA) for pharmacists providing RMMR and QUM services to ACFs. They are designed to assist pharmacists to exercise their professional judgement in individual circumstances, promote a consistently high quality of service and provide guidance to accredited and registered pharmacists on professional issues related to RMMR and QUM activities.

Changes to the funding and administrative arrangements have resulted in separation of RMMR and QUM services and necessitated the review of these guidelines.

It is important that pharmacists read these Guidelines in conjunction with relevant professional practice standards. Refer to the *Professional Practice Standards*, version 4, 2010 published by PSA.[8]

In general terms, **guidelines** are not definitive statements of correct procedure but are designed to provide advice or guidance to pharmacists on professional process issues, desired behaviour for good practice, and how responsibilities may be best fulfilled.

Standards are prescriptive statements of the minimum requirements necessary to ensure a service is delivered with a desirable level of acceptable or intended performance or results. Standards relate to the systems pharmacists should have in place for the delivery of a service and provide a benchmark against which performance can be assessed.

1.4 Scope

These Guidelines are based on the delivery of RMMR and QUM services to ACFs. It should be noted that the Guidelines concentrate on the best practices for implementation of RMMR and QUM services at ACFs, and are not intended to provide any clinical information. It is the responsibility of individual pharmacists to maintain their clinical skills, knowledge and competency.

Details of legislative requirements are not addressed in these Guidelines. It is expected that pharmacists will comply with relevant Commonwealth, State or Territory legislation governing therapeutic goods, drugs and poisons, pharmacists (health practitioners), pharmacies (premises), and privacy and confidentiality in the provision of these services.

It is expected that pharmacists will apply professional judgement in providing professional services and managing any risks associated with the provision of these services. Pharmacists will need to make risk-benefit assessments and other professional judgements from time-to-time based on the best available information. Any significant decisions should always be documented.[8] Pharmacists are reminded that they have a professional and legal responsibility to ensure that medicine is appropriate and safe for residents to use.[8]

1.5 Terminology

- **ACF** means an aged care facility which receives residential care subsidy in accordance with the Aged Care Act 1997[9] and includes nursing homes, hostels and multipurpose services (MPS).
- **Resident** means a person living permanently in an ACF who is not eligible for a Home Medicines Review.
- **Accredited pharmacist** means a registered pharmacist who holds a valid accreditation certificate from an accreditation body – the Australian Association of Consultant Pharmacy (AACP) or the Society of Hospital Pharmacists of Australia (SHPA).
- **Approved QUM MPS service provider** means a registered pharmacist or business that employs or has a service contract with one or more registered pharmacists to provide QUM services in a MPS on their behalf and has been approved to provide QUM services by the Department of Health and Ageing (DoHA).
- **Approved QUM service provider** means a registered pharmacist or business that employs or has a service contract with one or more registered pharmacists to provide QUM services in an ACF on their behalf and has been approved to provide QUM services by Medicare.
- **Approved RMMR MPS service provider** means a registered pharmacist or business who is either accredited, employs, or has a service contract with one or more accredited pharmacists to conduct RMMR services in a MPS on their behalf and has been approved to conduct RMMR services by DoHA.
- **Approved RMMR service provider** means a registered pharmacist or business who is either accredited, employs, or has a service contract with one or more accredited pharmacists to conduct RMMR services in ACFs on their behalf and has been approved to conduct RMMRs services by Medicare.
- C**omprehensive medical assessment (CMA)** includes a detailed medical history, medical examination, list of diagnoses or problems and written documentation of findings undertaken by a general practitioner (GP) of a resident in an ACF under Medicare Benefits Schedule Items 701, 703, 705 and 707.[10–12]
- **Health care team** may include the resident, carer, family member and/or next of kin, pharmacist, GP, nurse, ACF care team or other health care providers.
- **Medicare** means the Department of Human Services – Medicare (formally known as Medicare Australia).
- **Medication Review Standard** refers to Standard Four: Medication Review of the *Professional Practice Standards*, version 4, 2010 published by the PSA (see Appendix 3).
- **Multipurpose service (MPS)** means an integrated health and aged care service that provides flexible and sustainable service options for small rural and remote communities.[13]
- **MPS QUM service agreement** means an agreement between a QUM service provider and a MPS which details the scope of QUM services to be provided to that MPS.
- **MPS RMMR service agreement** means an agreement between a RMMR service provider and a MPS which details both the scope and provision of RMMR services to that MPS.
- **Pharmacist RMMR** means an Australian Government-funded service provided by an accredited pharmacist without GP referral. This can only occur in exceptional circumstances with prior approval from DoHA. Exceptional circumstances are determined by DoHA.
- **QUM service** means a service designed to assist ACFs in meeting the health care needs of residents and includes activities such as medication advisory activities, education and continuous improvement.
- **QUM service agreement** means an agreement between a QUM service provider and an ACF which details the scope of QUM services to be provided to that ACF.
- **RMMR** means an Australian Government-funded service that is characterised by the participation of both the GP and the accredited pharmacist in the medication review process, consistent with the business rules for Item 903 of the Medicare Benefits Schedule (MBS).
- **RMMR service agreement** means an agreement between a RMMR service provider and an ACF which details both the scope and provision of RMMR services to that ACF.

2.   Establishing RMMR services

2.1   Aim and focus

A RMMR aims to identify, prevent and resolve actual or potential medication-related problems, optimise pharmacotherapy and assist in positive health care outcomes.

The RMMR is a resident-focussed, collaborative, comprehensive medication review involving the systematic evaluation of the resident's complete medication regimen and management of that medicine in the context of other relevant clinical information and the resident's health status.

For a flow chart of the RMMR process see Appendix 1.

2.2   Accreditation requirements

An Australian Government-funded RMMR must be conducted by an accredited pharmacist in collaboration with a GP. An accredited pharmacist is a registered pharmacist who holds a valid accreditation certificate from an accreditation body to provide medication management reviews. AACP and SHPA are the only approved accreditation bodies. AACP and SHPA have developed criteria for assessment and accreditation to recognise those pharmacists who have the appropriate experience, knowledge and skills to provide medication reviews to the required standard. AACP requires mandatory reaccreditation assessment every three years and yearly evidence of completing continuing professional development. SHPA has annual reaccreditation requirements and full reassessment and certification every five years to ensure knowledge remains relevant and current.

Further information available at: www.aacp.moodle.com.au and www.shpa.org.au

2.3   RMMR service agreement

All Australian Government-funded ACFs are eligible to obtain access to RMMR services by entering into a RMMR service agreement with a RMMR service provider. The agreement may be terminated by the ACF or the approved RMMR service provider with 30 days prior written notice.

Further information is available at: www.medicareaustralia.gov. au/provider/pbs/fifth-agreement/files/model-rmmr-service-agreement.pdf

2.4   RMMR service provider

To become an approved RMMR service provider for an ACF, the applicant is required to:

a) be a registered pharmacist who is either an accredited pharmacist or employs or has a service contract with one or more accredited pharmacists to conduct medication reviews on their behalf; or

b) be a business that employs or has a service contract with one or more accredited pharmacists to conduct medication reviews on their behalf;

c) hold a current, valid RMMR service agreement with an Australian Government-funded ACF to provide RMMR services in that facility;

d) complete and sign the required application form, and send it to Medicare for approval along with the RMMR service agreement that has been signed by an authorised signatory of an ACF; and

e) have the above application approved by Medicare.

Further information available at: www.medicareaustralia.gov. au/provider/pbs/fifth-agreement/residential-medication-management-review.jsp

To become an approved RMMR service provider for a MPS, a MPS RMMR service agreement must be in place. Applications are approved by DoHA. A MPS RMMR service agreement and application form must be completed and submitted to DoHA for approval.

Further information available at: www.health.gov.au/internet/main/publishing.nsf/Content/fifth-community-pharmacy-agreement-professional-programs

2.5   Professional collaboration

Accredited pharmacists providing RMMRs to ACFs are strongly encouraged to collaborate with GPs, facility staff, residents and their families allowing for the successful implementation and continuation of RMMR services in ACFs.

A major benefit of creating an environment of collaboration is the establishment of relationships with key participants in the RMMR service. Holding face-to-face meetings with GPs and facility staff and associated health care providers have been shown to be critical in the establishment of effective working relationships. It is this relationship development that can be responsible for the effective uptake of the RMMRs by GPs and the facility.

Education and information sessions can be conducted by pharmacists to increase the awareness of the service and demonstrate how RMMRs can be integrated into the health care cycle of residents. GPs are able to access a range of Medicare items for health assessments in particular groups of people which may lead to the identification of a resident's need for a RMMR. These include general consultation items, specific health assessment items and chronic disease management items.

A RMMR is intended to assist the GP by identifying and advising on relevant medication-related problems. The accredited pharmacist collaborates with the GP and suggests strategies for effective and improved medication management with the resident's GP so optimal health outcomes for the

resident can be achieved. This process is facilitated if the accredited pharmacist and GP have an established professional relationship and an environment of trust exists between them.[14]

Further information on GP involvement in ACFs is available at: www.racgp.org.au/guidelinesGuidelines/silverbook

The RMMR service provider should collaborate with the QUM service provider, if they are different, to identify QUM activities that would most benefit the facility and its residents.

3.   RMMR process

3.1   Resident identification

The resident's GP, a community or accredited pharmacist, nursing staff, another member of the health care team, the resident themselves or their carer may identify the potential need for a RMMR.

A resident is eligible for a RMMR if they are a holder of a current Medicare or DVA card, and a permanent resident of a facility in which residential care services are provided, as defined in the Aged Care Act 1997.[9]

Generally, new residents should receive a RMMR as soon as possible after admission. Resident consent to participation in the RMMR is gained at the time of admission. It is the RMMR service provider's responsibility to ensure consent has been granted. For further information refer to section 6.1 Residents' rights, confidentiality and consent.

RMMRs are available to current residents on a clinical needs basis. Medicare benefits entitle eligible residents to one RMMR in any 12-month period, however, additional medication reviews may be clinically indicated when there has been a change in medical conditions or medication regimens, including but not limited to:

- discharge from hospital in the previous four weeks;
- significant change to medication 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;
- suspected non-compliance or problems with managing medication-related devices; or
- risk of, or inability to continue managing own medicines, due to changes in dexterity, confusion or impaired vision.

In such cases, an additional RMMR can be requested by the resident's GP. The RMMR service provider may notify the resident's GP when the clinical need for a RMMR arises. For residents indicated as being in urgent need of a medication review or have been re-admitted following discharge from hospital, the RMMR should be completed within seven –10 days of receiving the referral. The accredited pharmacist or ACF staff can contact the GP to initiate the review process.[8]

3.2   Conducting RMMR services

RMMR services must be conducted by an accredited pharmacist in collaboration with a resident's GP. All aspects of a RMMR, including resident and staff interviews, data collection, clinical assessment and report writing, must be conducted by an accredited pharmacist.

The RMMR process starts when the resident's GP provides the written referral, and clinical information to the RMMR service provider. The medical practitioner and RMMR service provider should agree on a preferred means for communicating issues and information relating to the provision of the RMMR. This should include the method(s) of initiating the RMMR, exceptions to the post review discussion, and the preferred method of communication, which can be done on a facility basis rather than on a resident-by-resident basis.

Only in exceptional circumstances, with prior approval from DoHA, can a RMMR be conducted by an accredited pharmacist without a referral from the resident's GP. Exceptional circumstances are determined by DoHA.

Further information is available at: www.health.gov.au/internet/main/publishing.nsf/Content/fifth-community-pharmacy-agreement-professional-programs

The accredited pharmacist should adopt a systematic approach when conducting the RMMR, which they should perform methodically, using an organised procedure to gather data, identify potential and actual medication-related problems, consult and decide upon the most appropriate options to remedy such problems and document findings and recommendations.[8]

The RMMR is based on the resident's clinical need and the approved RMMR service provider should notify a resident's GP if that need arises. In such cases, the GP then has the opportunity to initiate a RMMR. Procedures for obtaining a referral for a RMMR may be discussed with individual GPs and the facility through Medication Advisory Committees.

RMMR referrals are valid only if received on or before the date of the RMMR. Referrals cannot be made retrospectively. Referrals from GPs should meet the RACGP Standards stating the purpose of the referral as well as patient identification. RACGP Standards also state that "the person to whom the patient is referred receives sufficient relevant information

to manage the patient". In the case of RMMRs, that resident information is readily available in the resident's notes at the aged care facility. Essentially, referrals from GPs need to be in a manner that their peers would agree is suitable for the appropriate treatment of their patients and good medical practice. Referrals need to be signed and dated by the GP.

3.3 Gathering resident data

The accredited pharmacist gathers resident data and establishes a resident profile for each resident having a RMMR. The profile can be updated at each subsequent review to enable monitoring of clinical progress. Regular review of the resident's profile is vital to assess the appropriateness of the medication regimen in the context of a resident's clinical status.

Gathering resident information can be obtained directly from the resident, if appropriate, or from talking to their family, next of kin and staff members about the resident's history or current health issues.

The type and range of information gathered should include:

- demographic and/or personal information (resident name, Medicare/DVA/concession details, location in the facility, date of birth, gender, weight, height, body mass index);
- relevant social history (previous occupation, lifestyle, cultural factors, family and/or social support systems including authority/consenting rights, attitudes to health, illness and treatment, general understanding of current situation, health status, expectations);
- patient history (medical, surgical and/or specialist history, current conditions or co-morbidities, pathology and/or radiology investigations and results, allergies, previous adverse drug reactions); and
- resident assessment (status regarding frailty, vision, hearing, balance, cognition, memory, mood, gait, mobility, dexterity and rehabilitation, swallowing, oral and dental care, psychological status, nutrition and hydration, skin care and management of pain, continence, behaviour, sleep).[15]

The comprehensive information gathered about the resident and their medicine use provides context for the accredited pharmacist to use when identifying any medication-related problems.

3.4 Medication-related problems

A medication-related problem can be described as any undesirable event experienced by the resident that is thought to involve drug therapy, and that actually or potentially interferes with a desired outcome. These may include:[16]

- medicine use without indication – the resident is prescribed medicine in the absence of medical evidence, with no medically valid indication or PBS indication;
- untreated indication – the resident has a medical problem that requires drug therapy but is not receiving the appropriate therapy;
- improper drug selection – the resident has a medical indication but is prescribed the incorrect drug, or is taking a drug that is not the drug of choice or the most appropriate for the needs of the individual resident;
- sub-therapeutic dosage – the resident has a medical issue and is being prescribed too little of the correct medicine;
- over dosage – the resident has a medical issue and is being prescribed too much of the correct medicine;
- unnecessary medicine – the resident continues to take a medicine for a medical condition that has resolved;
- ineffective medicine is continued with evidence of a lack of desired outcome;
- adverse drug reactions – the resident has a medical issue that is the result of an adverse drug reaction, toxicity or adverse event;
- incorrect administration of a medicine e.g. crushing a sustained-release product or dosing at the wrong time;
- the medication order is poorly written or ambiguous creating confusion for facility staff;
- drug interactions – the resident has a medical issue that is the result of a drug-drug, drug-food or drug-laboratory test interaction; or
- failure to receive medicine – the resident has a medical issue but is not receiving prescribed medicine.

Evidence demonstrates that exposure to potentially inappropriate medicines in the elderly is associated with increased hospitalisation and attendance to emergency departments, increased harm, poorer health outcomes and even death.[17]

To aid accredited pharmacists recognise possible medication-related problems, there are several prescribing indicator tools that are designed to identify potentially inappropriate medicine prescribing especially in those over the age of 65 years. These include:

- START (Screening Tool to Alert doctors to the Right Treatment) which includes criteria indicating medicines that are considered beneficial, arranged according to physiological systems.[18]
- STOPP (Screening Tool of Older Persons' potentially inappropriate Prescriptions) which includes criteria indicating medicines which are considered inappropriate in the older person, including drug-drug and drug-disease interactions, medicines which adversely affect older consumers at risk of falls and duplicate drug

class prescriptions, arranged according to physiological systems.[19]

- Drug Burden Index, an evidence-based tool that measures a person's total exposure to medicines with sedative and anticholinergic properties which have been shown to impair cognitive and physical function.[20]
- Beers criteria, a list of medicines or classes of medicines that are considered inappropriate in the elderly population which remains a valuable tool for initial screening of prescribed medicines.[21]
- McLeod criteria, which is Canadian data similar to the Beers criteria.[22]
- The Medication Appropriateness Index (MAI) is an indexing system that measures drug therapy appropriateness for elderly consumers, using 10 criteria for each medicine prescribed.[23]
- Prescribing Indicators tool (Australian) has been developed to identify inappropriate medicines based on diseases commonly identified in older Australians aged over 65.[24]

Such tools can form an important part of the medication review process and should be considered as a reference and guide for accredited pharmacists.

3.5   RMMR report

Once identified, the clinical relevance of the medication-related problem should be assessed and prioritised. The accredited pharmacist should also consider the efficacy of the resident's medicine in the context of the resident's clinical status. A review of the appropriate alternatives and options should be conducted and prioritised for consideration by the GP.

The accredited pharmacist reviews the information collected from the resident profile, resident and staff interviews and other sources such as resident sleep, pain and incontinence charts to formulate recommendations for resolution or prevention of any identified medication-related problems. These recommendations may include medicine changes, resident education, nursing or care staff, strategies for improved medication adherence and further monitoring as well as comments on the actual or potential impact of the medicine on the resident.

A written report is provided to the GP containing details of any medication-related problems identified, as well as suggestions for resolution of these problems. Such strategies or recommendations need to be prioritised. Any critical issues should be verbally communicated to the GP. The written report for consideration by the GP should be communicated in a manner agreed upon by the facility and the GP. The GP retains responsibility for diagnosis, treatment decisions and prescribing. Changes to the resident's medication regimen will be determined by the GP, in consultation with the resident and/or

resident's family, the facility, and the accredited pharmacist, after consideration of the RMMR report in the context of the clinical and social status of the resident.

3.6   Documentation and reporting

The RMMR should be conducted and reported on in a timely manner. In general, the accredited pharmacist should complete the RMMR within two to four weeks of receiving the referral, or notify the referring health care provider if there is to be a delay (see Appendix 3 Criterion 4).

The accredited pharmacist should document that a RMMR has been conducted both in the resident's case notes, and also on their medication chart. A copy of the RMMR report and the GP medication management plan should be filed in the resident's case notes.

Any documentation should be presented in a manner that allows all parties involved in the RMMR process to view the identified problems, any recommendations, interventions and follow-up activities suggested, the date on which any action was taken and by whom. A record of the names of the resident, GP, specialist, pharmacy and/or nursing staff with whom contact was made and the dates of contact should also be included. All documentation should be stored in a safe and secure environment, for a minimum of seven years, which allows for timely retrieval and avoids unauthorised access to maintain privacy and confidentiality.

The accredited pharmacist should also provide medicine information and advice to nursing staff and carers, including requirements for medicine to be safely and correctly administered. The information should be designed to address staff or resident concerns, reduce confusion, and promote safe and appropriate use of medicines and adherence with the prescribed medication regimens. Information and advice regarding therapeutic device usage, storage, drug preparation and drug administration should also be included. The information should be provided both verbally and in written form, including the supply of consumer medicine information (CMIs) leaflets.

These processes assist in meeting Criterion 8 of the Medication Review Standard (see Appendix 3).

3.7   Follow-up and monitoring

The RMMR service involves a post-review discussion between the GP and the accredited pharmacist, unless exceptional circumstances apply.[25] It is strongly recommended that such communication involve a face-to-face component to develop trust and collaboration between the GP and the accredited pharmacist. Exceptions to mandatory post-review discussion should be stated

in the communications agreement between the GP and the pharmacist.

The post-review discussion is not mandatory if: [25]

- there are no recommended changes from the review;
- changes are minor in nature and do not require immediate discussion; or
- the pharmacist and GP agree that issues from the review should be considered in a GP multidisciplinary case conference.

Accredited pharmacists have a critical role to play in the effective monitoring of the efficacy and/or harm of each medicine used by the resident. They may recommend monitoring parameters for the resident, and then review results of monitoring to help evaluate therapeutic outcomes and recommend any required changes as a result of the monitoring process. The accredited pharmacist should follow-up and document outcomes from any subsequent visits and provide additional comments and recommendations where appropriate (see Appendix 3, Criterion 6).

3.8   Payment

Payments of a single prescribed fee for each RMMR conducted in an ACF are made by Medicare. The RMMR service fee is paid according to the date of service and is paid monthly once the claim form is submitted and approved by Medicare.

Payment for RMMRs conducted in a MPS is made by DoHA.

Medicare provides a rebate for GP involvement in a RMMR service. To claim a MBS Item 903 – RMMR, the GP needs to actively participate in the RMMR process by: [25]

- discussing and seeking consent for a RMMR from the eligible resident;
- providing input from the resident's comprehensive medical assessment and/or providing relevant clinical information which assists the accredited pharmacist in providing RMMRs to the resident;
- collaborating with the accredited pharmacist and discussing, where necessary, the pharmacist's recommendations and proposed medication management strategies;
- developing or revising a written medication management plan for the resident; and
- consulting with the resident (where possible) and/or next of kin/family to discuss the medication management plan and its implementation.

Further details of the claiming process available at: www.medicareaustralia.gov.au/provider/pbs/fifth-agreement/residential-medication-management-review.jsp

4.   Establishing QUM services

4.1   Aim and focus

QUM services focus on improving practices and procedures relating to medicine use in ACF. Services such as medication advisory activities, education and continuous improvement activities are designed to help facilities better meet the health care needs of residents.

Effective QUM services require committed teamwork between all members of the health care team including GPs, community pharmacists, nurses, facility staff, carers and management. Pharmacists play an important role in QUM through their promotion of appropriate treatment choices, effective communication with residents, prescribers and medicine administration staff, and assisting communication and collaboration between these parties.

4.2   QUM service agreement

A QUM service agreement is an agreement between a QUM service provider and an ACF, for the provision of QUM services. All Australian Government-funded ACF are eligible to access QUM services.

The QUM service agreement must include a work plan that details the agreed QUM activities between the facility and the approved QUM service provider. The QUM service provider, in consultation with the ACF, identifies a range of QUM activities that will assist in improving practices and procedures relating to medicine use in the ACF. A facility-wide approach to QUM must be adopted and all parties involved need to understand how such activities relate to the needs of the facility and the residents. Activities such as medication advisory activities, education and continuous improvement are specifically tailored to meet the needs of the facility.

The need for continuous improvement activities such as assessing residents' ability to self-administer medicine and medication audits and surveys may be identified by the accredited pharmacist during a RMMR. The QUM service provider should collaborate with the RMMR service provider, if they are different, to identify QUM activities that would most benefit the facility and its residents. The type and frequency of QUM services are documented in the service agreement between the QUM service provider and the ACF. The QUM activities decided upon must include activities from the approved list of QUM activities. However, other QUM activities may be conducted as detailed in the QUM service agreement. For examples of these activities see Appendix 3.

Only one QUM service provider may be approved for each ACF.

Further details are available at: www.medicareaustralia.gov.au/provider/pbs/fifth-agreement/files/model-qum-service-agreement.pdf

4.3   QUM service provider

To become an approved QUM service provider for an ACF the applicant is required to:

a) be a registered pharmacist or employs, or has a service contract with, one or more registered pharmacists to conduct QUM services on their behalf; or

b) a business that employs or has a service contract with one or more registered pharmacists to conduct QUM services on their behalf;

c) hold a current, valid QUM service agreement with an Australian Government-funded ACF to provide QUM services in that facility;

d) complete and sign the required application form, and send it to Medicare for approval along with the QUM service agreement that has been signed by an authorised signatory of an ACF; and

e) have the above application approved by Medicare.

The approved QUM service provider ensures that QUM services are conducted by a registered pharmacist who is able to respond appropriately to requests from the ACF and the provided services adhere to recognised professional standards. The approved QUM service provider is responsible for ensuring that the service agreement entered into with the ACF constitutes a valid QUM service agreement.

To become an approved QUM service provider for a MPS, a QUM MPS service agreement must be in place. Applications are approved by DoHA. A QUM MPS service agreement and application form must be completed and submitted to DoHA for approval.

Further information is available at: www.medicareaustralia.gov. au/provider/pbs/fifth-agreement/files/4640-mmr-programs-app.pdf

5.   Quality Use of Medicines (QUM) services

5.1   QUM services

QUM services for which the QUM service provider may be entitled to remuneration from Medicare as listed in the QUM service agreement include the following general categories:

- Medication advisory activities
- Education activities
- Continuous improvement activities.

The QUM service provider must conduct at least one of the QUM services included in Schedule 1 of the agreement per quarter to be eligible for remuneration by Medicare. Other QUM services may be agreed with the ACF but these services are not entitled to remuneration by Medicare.

Further information is available at: www.medicareaustralia.gov. au/provider/pbs/fifth-agreement/quality-use-of-medicines.jsp

5.2   Payment

Payment for QUM services provided by approved QUM service providers to ACF in accordance with the signed service agreement, are paid by Medicare. QUM payments are based on the number of eligible aged care places at the facility as stated in the application form. A minimum of one QUM service must be provided each quarter to receive the QUM payment.

Payment for QUM services provided by approved MPS QUM service provider to a MPS in accordance with the signed service agreement, are paid by DoHA.

6.   Essential components of RMMR and QUM services

6.1   Residents' rights, confidentiality and consent

Each resident's right to privacy, dignity and confidentiality should be recognised and respected. An integral part of best practice in medication management in ACFs is observing residents' rights. These rights and responsibilities are provided under the *Aged Care Act 1997*, Part 4.2 (User Rights Principles 1997) and are outlined in the Charter of Residents' Rights and Responsibilities in *The Residential Care Manual* developed by the Department of Health and Ageing.[26]

Pharmacists should respect and safeguard the resident's right to privacy and confidentiality at all times. Confidentiality needs to be maintained through the development of secure files (either electronic or in a secure filing cabinet). This includes ensuring that any resident information that is transmitted electronically uses encrypted or secure electronic messaging to enhance security. At no time should resident information be shared with unauthorised people, resident's relatives or other health care providers without the consent of the resident or their representative.

Pharmacists should refer to any State or Territory privacy legislation or health privacy frameworks. Pharmacists are also required to meet the relevant professional practice standards. Refer to Criterion 3 of the *Fundamental Pharmacy Practice* Standard of the *Professional Practice Standards*, version 4 in the provision of RMMR services.[8]

Where resident data is required to be disclosed to staff from the Department of Health and Ageing, Medicare or the Standards and Accreditation Agency, informed consent has to be obtained from the resident or their representative.

Resident consent also needs to be obtained for medication reviews and QUM services to be conducted and the associated sharing of necessary information between health care

providers. This should be obtained as part of the ACF's admission procedures. The approved RMMR and QUM service providers should confirm with the ACF that appropriate consent has been obtained from eligible residents before RMMRs and QUM services are conducted.

6.2   Communication

All staff involved in residents' care need to be aware that medication management is not an isolated pharmacist activity, but rather collaborative and multidisciplinary where all stakeholders play a role. All pharmacists working in ACFs can use their specialist drug knowledge and experience in developing safe systems for medicines and monitoring medication use to make an important contribution to the work of multidisciplinary teams. [27]

It is critical to the success of RMMR and QUM services that effective communication and collaborative working relationships are established and maintained with all members of the health care team. The approved RMMR and the approved QUM service providers play pivotal roles in ensuring adequate communication exist between the pharmacist and the residents' GPs, the Director of Nursing or authorised representative, ACF nursing and other staff, other health care providers and the pharmacy supplying the residents' medicines. Regular face-to-face communication should be encouraged whenever possible to foster better working and collaborative relationships. The quality of any interaction is dependent on trust as health care team members need to be confident that the information they receive from each other is reliable and accurate. This is an essential element of establishing relationships of trust, which is the basis for cooperation. [14]

RMMR and QUM service providers need to communicate with residents, GPs, staff members, other health providers and to each other to gather and convey relevant medication-related information. When the RMMR and QUM service providers are different, communication needs to exist to allow optimal transfer of information. The RMMR service provider, when conducting RMMRs may identify QUM activities that may be beneficial in the ACF such as specific drug usage reviews. This needs to be communicated to the QUM service provider. QUM service providers may need to communicate results from surveys and reviews and provide educational sessions to the local and regional MAC, GPs and facility staff using the established facility protocols for communication.

Formal arrangements for structured and documented communication and coordination should be in place between all involved parties. Any reports and communication on issues and information relating to the RMMR and QUM services should be communicated in a way agreed upon by all parties involved, with confidentiality of the information a prime

consideration. This may include postage, personal delivery, and fax with coversheet containing disclaimer. Emails should only be provided if they are encrypted to ensure secure messaging. These processes are consistent with Criterion 3 of the Medication Review standard (see Appendix 3).

6.3   Policy, procedures and documentation

a) Resident and record access

After both the RMMR and QUM service agreements have been developed and signed, the RMMR and QUM service providers are required to develop and agree to protocols regarding access to residents, medical records and ACF staff by the pharmacists.

b) Documentation

Effective documentation is essential to maximise safety, quality and efficiency throughout the RMMR and QUM services. All pharmacists involved in the RMMR and QUM services must maintain accurate documentation for all services provided, record all activities undertaken and strategies developed. Both the RMMR and QUM service providers must keep full and accurate records and reports of each service that has been provided for seven years. Storage of all documentation should be done in a safe, systematic and secure manner that allows timely and accurate retrieval while reducing the risk of unauthorised access and failure of confidentiality. These processes assist with meeting Criterion 5 of the Medication Review Standard (see Appendix 3).

Further information available at: www.medicareaustralia. gov.au/provider/pbs/fifth-agreement/files/model-qum-service-agreement.pdf

The RMMR service provider should create and maintain a comprehensive medication profile. This information may come from several sources, including the medication chart and resident case notes. CMAs, hospital discharge summaries, reports from other health professionals and laboratory test results should also be considered (see Criterion 7 of the Medication Review Standard at Appendix 3).

The medication profile should include:

- all current medicines, including prescription and non-prescription, complementary medicines, dose administration aids, therapeutic devices and appliances;
- dose, strength, dose form, directions, route of administration and duration of therapy for each medicine;
- when necessary ('prn') medicines and the frequency of their administration;
- short term medicines (e.g. antibiotic courses); and
- medicine administration instructions.

6.4 Standards and Guidelines for aged care facilities

The Accreditation Standards and Guidelines for aged care facilities, detailed in the *Quality of Care Principles* of the *Aged Care Act 1997*, Residential Care Manual,[26] Standards and Guidelines for Residential Aged Care Services Manual[28] and Documentation and Accountability Manual reflect the quality management and services expected of a residential aged care service. Residential aged care services are assessed against these standards to determine their suitability for accreditation by the Aged Care Standards and Accreditation Agency.[14]

To ensure 'residents' medicine is managed safely and correctly' as detailed in Standard 2.7 (Medication Management) of the ACF accreditation standards, ACFs should have policies and practices to ensure that:

- there is safe administration and storage of medicines;
- incident reporting mechanisms are present, functional and acted upon;
- medication orders are written legibly and are available to administering staff; and
- residents' medicine is regularly reviewed by appropriate health professionals.

RMMR and QUM services provided to ACFs may also assist in achieving expected outcomes in a number of other accreditation standards. Further information available at: www.accreditation.org.au/accreditation/accreditationstandards

The *Guidelines for medication management in residential aged care facilities* were developed by the Australian Pharmaceutical Advisory Council (APAC) to reflect the accreditation standards for aged care facilities and other relevant legislation.[29] The recommendations made in the Guidelines relate to policies and procedures in individual facilities to ensure that all areas of medication management and decision making function together as a coordinated program utilising the skills of multi-disciplinary teams.

A resource kit has been developed to assist pharmacists by providing practical, easy-to-use tools and templates to assist with the implementation of the APAC Guidelines available at: www.health.vic.gov.au/dpu/resource-kit.htm

7. Resources

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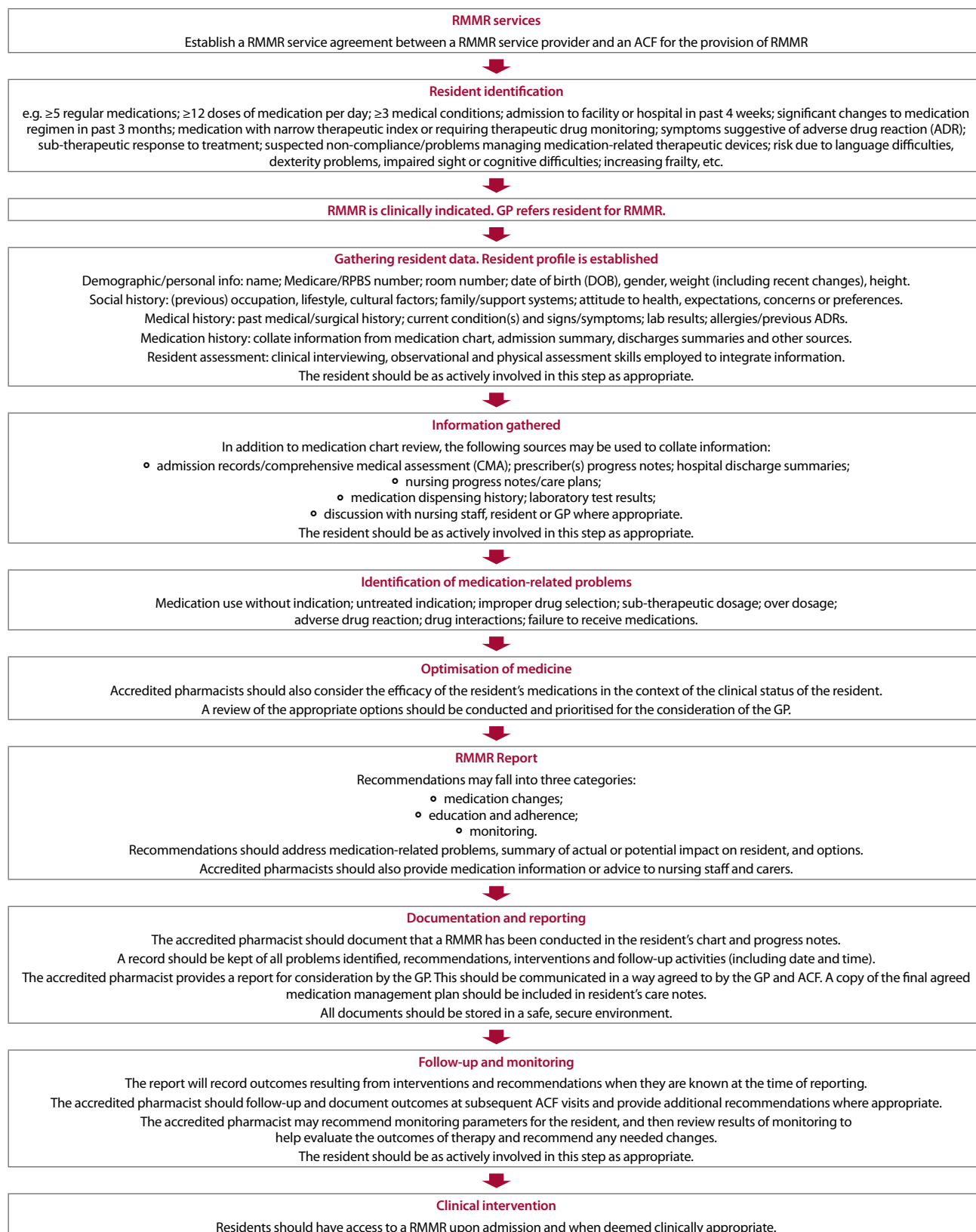evaluation_due_programs/due_kit_for_care_homes

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Appendix 1. RMMR Flowchart

RMMR services

Establish a RMMR service agreement between a RMMR service provider and an ACF for the provision of RMMR

⬇

Resident identification

e.g. ≥5 regular medications; ≥12 doses of medication per day; ≥3 medical conditions; admission to facility or hospital in past 4 weeks; significant changes to medication regimen in past 3 months; medication with narrow therapeutic index or requiring therapeutic drug monitoring; symptoms suggestive of adverse drug reaction (ADR); sub-therapeutic response to treatment; suspected non-compliance/problems managing medication-related therapeutic devices; risk due to language difficulties, dexterity problems, impaired sight or cognitive difficulties; increasing frailty, etc.

⬇

RMMR is clinically indicated. GP refers resident for RMMR.

⬇

Gathering resident data. Resident profile is established

Demographic/personal info: name; Medicare/RPBS number; room number; date of birth (DOB), gender, weight (including recent changes), height.
Social history: (previous) occupation, lifestyle, cultural factors; family/support systems; attitude to health, expectations, concerns or preferences.
Medical history: past medical/surgical history; current condition(s) and signs/symptoms; lab results; allergies/previous ADRs.
Medication history: collate information from medication chart, admission summary, discharges summaries and other sources.
Resident assessment: clinical interviewing, observational and physical assessment skills employed to integrate information.
The resident should be as actively involved in this step as appropriate.

⬇

Information gathered

In addition to medication chart review, the following sources may be used to collate information:
○ admission records/comprehensive medical assessment (CMA); prescriber(s) progress notes; hospital discharge summaries;
○ nursing progress notes/care plans;
○ medication dispensing history; laboratory test results;
○ discussion with nursing staff, resident or GP where appropriate.
The resident should be as actively involved in this step as appropriate.

⬇

Identification of medication-related problems

Medication use without indication; untreated indication; improper drug selection; sub-therapeutic dosage; over dosage;
adverse drug reaction; drug interactions; failure to receive medications.

⬇

Optimisation of medicine

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

⬇

RMMR Report

Recommendations may fall into three categories:
○ medication changes;
○ education and adherence;
○ monitoring.
Recommendations should address medication-related problems, summary of actual or potential impact on resident, and options.
Accredited pharmacists should also provide medication information or advice to nursing staff and carers.

⬇

Documentation and reporting

The accredited pharmacist should document that a RMMR has been conducted in the resident's chart and progress notes.
A record should be kept of all problems identified, recommendations, interventions and follow-up activities (including date and time).
The accredited pharmacist provides a report for consideration by the GP. This should be communicated in a way agreed to by the GP and ACF. A copy of the final agreed medication management plan should be included in resident's care notes.
All documents should be stored in a safe, secure environment.

⬇

Follow-up and monitoring

The report will record outcomes resulting from interventions and recommendations when they are known at the time of reporting.
The accredited pharmacist should follow-up and document outcomes at subsequent ACF visits and provide additional recommendations where appropriate.
The accredited pharmacist may recommend monitoring parameters for the resident, and then review results of monitoring to help evaluate the outcomes of therapy and recommend any needed changes.
The resident should be as actively involved in this step as appropriate.

⬇

Clinical intervention

Residents should have access to a RMMR upon admission and when deemed clinically appropriate.

Appendix 2. QUM Flowchart

QUM services

Establish a QUM service agreement between a QUM service provider and an ACF
for the provision of associated QUM services.

▼

Types of QUM activities[30]

A range of facility-focused activities, best catered to the facility in question, should be provided. These may include:

▼

Medication advisory

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

Education

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

Continuous improvement

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

Appendix 3. Professional Practice Standard 4 – Medication review
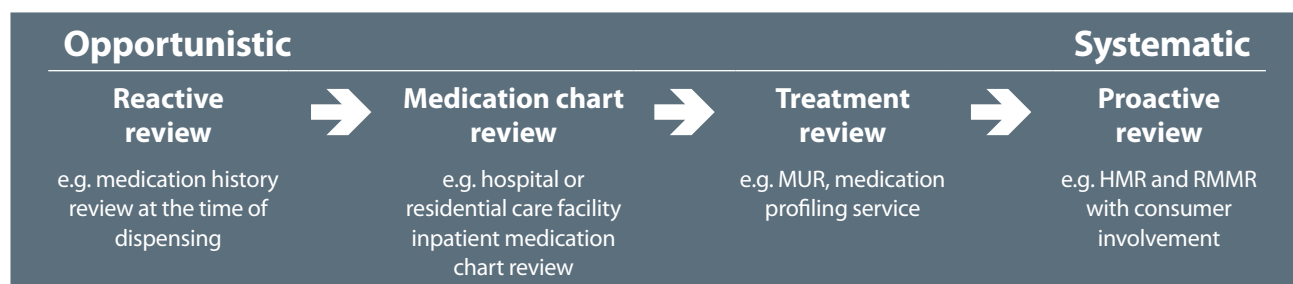
Standard

The pharmacist works with the consumer, and other health care providers, to systematically review the consumer's medication regimen, identify potential areas for improvement, and provide information and advice to optimise health outcomes.

Scope of this standard

- A 'medication review' is a systematic assessment of a consumer's medications and the management of those medications, with the aim of optimising consumer health outcomes and identifying potential medication-related issues within the framework of the quality use of medicines.

- The term 'medication review' encompasses a continuum of processes in various formats and complexities, ranging from an opportunistic discussion to a more comprehensive and proactive approach to reviewing the consumer's medication regimen (see Figure 1).

- This standard covers the key principles underpinning all types of systematic medication review services under any service arrangement including, but not limited to: hospital inpatient medication reviews, medication profiling services,

Home Medicines Reviews (HMRs), Residential Medication Management Reviews (RMMRs), and Medicines Use Reviews (MURs). Opportunistic medication history reviews that are conducted during the dispensing process are covered in Standard 5: Dispensing.

- This standard is to be applied in conjunction with the Fundamental Pharmacy Practice and Counselling standards. Refer also to the Health Promotion standard, where appropriate.

- Pharmacists providing medication reviews should also be familiar with the relevant professional guidelines and business rules relating to these services, where available. For specific service-related information, refer to the relevant Professional Practice Guidelines for each individual service.

Figure 1. Medication review services fall along a continuum of increasing complexity. More complex services require additional training and skills from a pharmacist.

Opportunistic			Systematic
Reactive review	**Medication chart review**	**Treatment review**	**Proactive review**
e.g. medication history review at the time of dispensing	e.g. hospital or residential care facility inpatient medication chart review	e.g. MUR, medication profiling service	e.g. HMR and RMMR with consumer involvement

NOTE: HOME MEDICINES REVIEWS WERE FORMERLY KNOWN AS DOMICILIARY MEDICATION MANAGEMENT REVIEWS (DMMRs).

CRITERIA/INDICATORS	SELF CHECK: YES/ NO/NA	RESOURCES
Criterion 1: The pharmacist maintains the relevant level of competency necessary to undertake the specific medication review service		
1. Has completed the appropriate level of training and credentialing for the medication review service being delivered		• Australian Association of Consultant Pharmacy. www.aacp.com.au

2. Maintains currency of the knowledge and skills required to deliver the medication review service		– AACP Competency Map: Medication Management Reviews
		  – Accreditation diagram
		  – HMR Mentoring Service

3. Accesses appropriate resources to support service delivery		– Fact sheet 5. Reaccreditation for MMRs • Society of Hospital Pharmacists of Australia. MMR [Medication Management Review] accreditation. www.shpa.org.au
Criterion 2: The pharmacist works collaboratively with the consumer and other health care providers		
1. Determines and uses the preferred method of communication for the consumer and other health care providers		• Pharmacy Guild of Australia. Medication Management Review Program. Communication and concordance module. www.guild.org.au
2. Ensures the consumer has provided informed consent for both the service and for communication with their other health care provider(s)		
3. Conducts the medication review in an environment that meets the needs of the consumer		
4. Liaises with any other pharmacists involved in the medication review service to ensure all tasks are completed and follow-up occurs if required		
Criterion 3: The pharmacist follows a systematic procedure for conducting the medication review		
1. Forms an agreement with any other pharmacists involved in different aspects of the review to ensure all tasks are performed		• Australian Association of Consultant Pharmacy. www.aacp.com.au
2. Conducts a consumer interview to compile a medication history, unless direct communication with the consumer is not possible		– AACP Procedures and Resources Manual: Medication Management Review – Framework Document for Domiciliary Medication Management Reviews
3. Reviews consumer's current medication, utilises consumer files, pharmacy records, and information from other health care providers to further inform the medication review		• Society of Hospital Pharmacists of Australia. SHPA standards of practice for clinical pharmacy. Appendix A: Accurate medication history. J Pharm Pract Res 2005;35:122–46
4. Assesses adherence and provides advice on how to improve adherence if necessary		• Pharmaceutical Society of Australia. www.psa.org.au – Guidelines for pharmacists: Domiciliary Medication Management Review
5. Assesses the consumer's medication regimen and identifies potential medication-related issues		– Guidelines and Standards for the Collaborative and Pharmacist Residential Medication Management Review (RMMR) Program and Associated Quality Use of Medicines (QUM) Services – Medication Profiling Service [Guidelines and standards] • Pharmacy Guild of Australia. Quality Care Pharmacy Program. Home Medicines Review checklist (T3F). www.guild.org.au/qcpp

CRITERIA/INDICATORS	SELF CHECK: YES/ NO/NA	RESOURCES
Criterion 4: The pharmacist conducts the medication review and reports findings, where relevant, in a timely manner		
1. Completes the medication review within 2–4 weeks of receiving the referral or notifies the referring health care provider if there is to be a delay		
2. Completes medication reviews initiated upon hospital discharge, or those indicated as urgent, within 7–10 days of receiving the referral		
Criterion 5: The pharmacist maintains accurate documentation for the medication review service provided		
1. Records all activities undertaken and strategies developed in the course of a medication review		• Australian Association of Consultant Pharmacy. AACP sample agreement between HMR Service Provider and the Accredited Pharmacist. www.aacp.com.au
2. Stores all medication review documentation in a safe, systematic and secure manner that allows timely and accurate retrieval		
3. Prepares a comprehensive report documenting recommendations, if relevant		
Criterion 6: The pharmacist addresses and follows up any issues arising from the medication review		
1. Addresses any current, or potential, medication-related issues identified in the medication review, in conjunction with other health care providers, where appropriate		
2. Prioritises any identified issues and addresses them in a timely manner		
3. Promptly communicates to the appropriate health care provider any findings that may seriously affect the consumer's health		
4. Records any follow-up actions resulting from the medication review, if known		
Criterion 7: The pharmacist creates and maintains a comprehensive medication profile with involvement from the consumer and their other health care providers		
1. Uses suitable computer software to record relevant consumer details in the medication profile		• Pharmaceutical Society of Australia. *Medication Profiling Service* [Guidelines and standards]. www.psa.org.au
2. Maintains a medication profile for each consumer that is current and complete at the time of review		• National Prescribing Service. Medicines list. www.nps.org.au
3. Shares and discusses details of the medication profile with the consumer, including how it can be used as a resource to improve continuity of care		• Australian Government Department of Health and Ageing. Medi-list. www.health.gov.au
4. Obtains relevant information from the consumer's other health care providers as required		

CRITERIA/INDICATORS	SELF CHECK: YES/ NO/NA	RESOURCES
Criterion 8: The pharmacist provides the consumer and other health care providers with relevant information to optimise health outcomes		

1. Provides accurate and relevant written and verbal information to the consumer's other health care providers as needed		• Pharmacy Guild of Australia. www.guild.org.au
		  – Medicines Information to Consumers Program
		  – When to Provide Consumer Medication Information
		• Pharmaceutical Society of Australia. www.psa.org.au
		  – Consumer Medicine Information and the Pharmacist
		  – Guidelines for Pharmacists on Providing Medicines Information to Patients
		  – Self Care Fact Cards
		• Consumer Medication Information. www.medicines.org.au
		• National Prescribing Service. www.nps.org.au
		  – Consumer Medicine Information (CMI) search
		  – NPS patient resources for health professionals
		• HealthInsite. www.healthinsite.gov.au
		• Professional Practice Standard 3: Counselling, p. 20

2. Maintains access to current sources of evidence-based information about medicines, therapeutic devices, and lifestyle issues		
3. Provides the consumer with written and oral information and advice appropriate to their needs		
4. Demonstrates and observes the use of any therapeutic devices, aids, and systems designed to assist in medication use and adherence		
5. Provides any other pharmacists involved with the medication review with relevant information to ensure continuity of care		

Additional references

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Notes

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