His Excellency General the Honourable David John Hurley AC DSC (Retd), Governor-General of the Commonwealth of Australia, and Her Excellency Mrs Linda Hurley, Patrons

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Australian Commission on Safety and Quality in Health Care
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Feedback on the Quality Use of Medicines in Aged Care

I write in response to the *Quality Use of Medicines and Medicines Safety: Discussion paper for public consultation – Phase 1: Aged Care*, intended to inform the development of the Quality Use of Medicines National Health Priority Area. Thank you for the opportunity to provide input.

Palliative Care Australia (PCA) is the national peak body for palliative care and represents all those who work towards high quality palliative care for all who need it. PCA has reviewed the discussion paper and is concerned that there is no specific mention of palliative care and the quality use of medicines and medicine safety for palliative care patients and medications.

Needs of Patients

As 36% of all Australians who die do so in residential aged care, palliative care forms part of any high-quality aged care service. Timely access to appropriate medicines based on best evidence is a core tenant of good palliative care. All Australians receiving palliative care, including those receiving aged care services, must be able to access symptom assessment, medication review by professionals with palliative care expertise and the necessary medicines for their management, including opioids, to manage pain, breathlessness and other symptoms.

By achieving adequate and sustained symptom control, people receiving palliative care through their generalist and/or specialist practitioner(s), are supported to remain in the setting of their choice, such as home or in residential aged care. Those living in residential aged care with palliative care needs often have multiple comorbidities, and the clinical course includes intercurrent clinical problems and change in clinical status as the person deteriorates. This necessitates the use of multiple medications both for the underlying condition and also for symptom management, and the choice, dose, route and appropriateness of these medicines will change quite regularly. Medication assessment is hence a critical part of quality palliative care and requires specific expertise in palliative care. Providing access to palliative care and palliative care specialists ensures that aged care recipients have their medications regularly monitored, reducing the use of inappropriate medicines, optimising symptom management without toxicity, and having

the required conversations with the resident and their family decision-makers about the goals of the medication therapy.

Needs of Prescribers

For residents requiring palliative care, quality use of opioids is a particular area of focus. PCA supports approaches which optimise opioid management for those for whom the evidence supports benefit, that ensures all prescribers are enabled to prescribe, in a timely manner, appropriate opioids for pain and breathlessness management for residents with palliative care needs, without the burden of unnecessary regulatory barriers, with the appropriate education and training to feel confident in their appropriate use and specialist support where necessary. This must be further supported by ensuring an adequate supply and imprest stock of minimum levels of opioids commonly used in palliative care in acute facilities, community pharmacies and out of home settings such as residential aged care facilities, with processes in place to manage planned or emergency shortages. If timely access to prescribers is limited or prescribers are not familiar with contemporary medication regimes, including anticipatory prescribing, access to medications may be delayed or not forthcoming causing patients to suffer unnecessarily. Additionally, if suitably qualified staff are not on site to administer prescribed regular or breakthrough medication, residents may be left with poorly managed symptoms.

We note that appropriately, the inappropriate use of antipsychotics is covered in depth in the discussion paper. This section would be enhanced if similar consideration was provided for delirium, which is also a common clinical condition in residential aged care, is particularly complex when it occurs in someone with dementia, and for which under-detection and inadequate management occurs. We note there are specific situations where antipsychotics may be used in symptom management (nausea, refractory perceptual disturbance or agitation due to delirium) under the supervision of a clinician with palliative care expertise/knowledge.

Access to clinical expertise

The management of symptoms for residents with palliative care needs requires expertise in symptom assessment, and the delivery of a suite of therapeutic approaches in partnership with medication, hence the optimisation of nonpharmacological measures is also critical for quality use of medicine. It also requires clinical expertise to assess the need for, administer and then monitor response of *pro re nata* (prn) medications. Important symptoms which are common in residential aged care include pain, breathlessness and delirium, due to the nature of the medical conditions and also the frequency of dementia. Clinical expertise also is needed in assessing symptom distress in those with cognitive impairment.

Advance Care Planning and shared decision-making about goals of care

Involvement of the resident and their decision-makers in discussions about goals of care and future wishes are important to support better use of medications by ensuring that older Australians are able to be fully informed about the benefits and harms of medicines, and therapeutic choices for their underlying condition(s) and symptoms; and to have a say about what medications they want at each stage of their palliative care journey. As people transition between different care and health settings, these discussions can support patients to receive the treatment they need and want, and potentially avoid the use of unnecessary drugs and polypharmacy. It is therefore critical that health professionals who are equipped with the skills to communicate with

residents about the net clinical benefit of their medicines within the context of their clinical condition, and promote shared decision-making, be a core element of initiatives aiming to deliver the Quality Use of Medicines in aged care.

Processes for medicines review by pharmacy and medication experts (for example RMMR (resident medication management review), also need to integrate information from a contemporaneous resident clinical assessment and involve the interdisciplinary team so that advice can be tailored to the resident's individual clinical needs[1].

You may be interested to know that PCA recently launched an eight-point plan for palliative care in aged care to highlight the current key issues in the aged care sector and provide constructive solutions. Further information is available at: https://palliativecare.org.au/palli8-core-business-in-aged-care#

Thank you again for the opportunity to input into this process. PCA seeks commitment from the Commission to include palliative care and advance care planning as part of any response to improving the Quality Use of Medicines in aged care. PCA would welcome the opportunity to be consulted on any proposed changes impacting palliative care medicines and the needs of palliative care patients, now and into the future. I have also attached for your information a copy of the PCA position statement 'Sustainable access to prescription opioids for use in palliative care' developed in conjunction with a range of specialist health and palliative care organisations.

If you have any queries in relation to the issues outlined above, please contact Ms Katie Snell, Aged Care Policy Advisor, on 0402 422 611 or at katie.snell@palliativecare.org.au.

Yours sincerely

Rohan Greenland
Chief Executive Officer
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[1] See Disalvo, D, Luckett T, Bennett A, Davidson P, Agar, M (2020), 'Multidisciplinary perspectives on medication-related decision-making for people with advanced dementia living in long-term care: a critical incident analysis,' *European Journal of Clinical Pharmacology* **volume 76**, pp 567–578.