

# Supply and PBS Claiming from a Medication Chart in Residential Aged Care Facilities

Organisation	Services for Australian Rural and Remote Allied Health (SARRAH)
Address	P.O. Box 74 Deakin West ACT 2600
Contact Information	Rod Wellington – Chief Executive Officer BH – 02) 6285-4960 Email – <a href="mailto:rod@sarrah.org.au">rod@sarrah.org.au</a>  This paper was produced with the assistance of Lindy Swain Pharmacist Academic and member of the SARRAH Advisory Committee.

## Overview

In a Residential Aged Care Facility (RACF), medication charts are often used as:

- a record of the prescriber’s clinical intention for a resident’s treatment;
- an order for the pharmacy for the supply of a resident’s medicine; and
- the record of administration of the medicine to the resident by a nurse.

Currently there is a legislative requirement for a written prescription to enable the dispensing, supplying and claiming of the PBS/RPBS benefit by a pharmacist. Consequently there is a duplication of tasks for prescribers in completing the medication chart and the PBS/RPBS prescription form.

The aim of the Medication Charts initiative is to introduce supply and claiming of PBS medicines from a medication chart in RACFs. Implementing this initiative will provide benefits to residents by facilitating supply using a single source of information. It will also assist the quality use of medicines by providing the pharmacy with timely notice of updates and changes to a resident’s medication regimen, ensuring that the prescriber’s most recent intentions for the resident’s clinical care are promptly implemented. Streamlining the process will also create administrative efficiencies for prescribers, RACF staff and pharmacists, such as a reduction in paperwork required to prescribe and supply a medication for a patient.

**SARRAH strongly supports the medication chart in RACFs being used instead of a written prescription for supply and claiming purposes.**

Many pharmacies already supply RACF patients from the medication chart and spend many hours chasing “owing” prescriptions. Standardised medication charts are needed and with a strong preference for typed, rather than hand written charts.

Prescribers must include remote nurses and nurse practitioners, general practitioners, registrars and medical specialists to account for areas where there are no or scarce medical practitioners. SARRAH would support rural and remote pharmacists to become prescribers within certain frameworks and guidelines, and if accredited to do so.

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## Issues for Discussion

Comments are provided against the questions raised in the consultation paper.

1. Currently many medication charts are faxed to pharmacies which historically has operated effectively. It is however acknowledged that secure emailing of scanned charts or electronic transfer over secure internet would be preferred. Most pharmacies and RACFs have computer hardware but not the software for secure transfer of information via the internet.

The iCare system is used by a number of RACFs and pharmacies which allows all clinicians and pharmacists to access the patient medication chart.

All medication charts must have the date and time of writing noted. Medication charts must not only be written but changes signed and dated by a medical practitioner. Pharmacists must check the time and date of the chart.

Currently many pharmacists are supplying schedule and authority medications from a regular medication chart. To enable claiming of schedule and authority prescriptions easier it is suggested that these drugs be written on a separate chart (not a special document but just a separate chart/form). Too many different types of charts will create confusion.

2. a. Pharmacy technicians, as well as nurses and all medical practitioners, including specialists, should be able to access a resident's chart, electronically and on paper. Pharmacy technicians should be able to dispense direct from a patient's electronic medication chart. The fewer steps in the process will equate to a reduction in the error rate.

In rural and remote areas appropriately trained Aboriginal Health Workers (AHWs) and nurses need to be able to access health records and medication charts as they will be the people dispensing the medication, and there may be no supervision by a pharmacist or medical practitioner.

b. Medical practitioners and pharmacists should have authorisation to amend the medication chart. Often a medical practitioner may provide instructions to a pharmacist over the telephone and in these circumstances the pharmacist needs to change and sign the medication chart.

c. The medication prescriber should take overall responsibility for the chart. In rural and remote settings the medication prescriber may be a nurse.

Pharmacists and nurses or AHWs who dispense must keep paper and electronic copies of all medication charts and be able to justify all medications dispensed.

3. SARRAH supports consistent medication charts. A customised space for each facility would allow doctor/nurse instructions, such as phone conversations, to be noted. Patient "special" considerations could also be noted.

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4.
  - a. If practitioners are prescribing and claiming off a medication chart repeats may not be required. This practice only confuses the process.
  - b. Not dispensing a script occurs by crossing it through and writing not dispensed. This practice does not need to defer. If the medication is required it should be entered onto a new medication chart. Electronic charts require a cross through rather than a delete function.
  - c. To change a medication or dose, prescribers should cross through old and write on a new document - that is start a new "box".
5. Prescribers generate their owing scripts from a pharmacist or nurse request list. Telephone orders are often written on a chart by a nurse or pharmacist and signed by the prescriber at a later date.
6. Mandated checking procedures need to be implemented both at the RACF and pharmacy. Targeted training would be very useful if not essential.