

15 May 2023

Clinical Care Standards Secretariat
Clinical Care Standards Program
Australian Commission on Safety and Quality in Health Care
GPO Box 5480 Sydney NSW 2001
Email: CCS@health.gov.au

Dear Secretariat,

**Feedback on the Draft Psychotropic Medicines in Cognitive Disability or Impairment
Clinical Standard**

Thank you for the opportunity to comment on the draft *Psychotropic Medicines in Cognitive Disability or Impairment Clinical Standard*. ACCPA welcomes the development and implementation of the standard which we believe will result in better care for older people with cognitive disability or impairment.

In reviewing the draft standard, ACCPA notes that the Commission has recently completed consultation process on the draft *Clinical Practice Guidelines for the Appropriate Use of Psychotropic Medications in People Living with Dementia and in Residential Aged Care*. Considering that Dementia is typically diagnosed when acquired cognitive impairment has become severe enough to compromise social and/or occupational functioning,¹ it is important that this standard aligns with the proposed clinical practice guidelines, where appropriate.

Overall, ACCPA believes the standard is very comprehensive and, according to Members (with embedded pharmacists) who responded to ACCPA request for feedback, aligns well with their policies and procedures in this area. The following are ACCPA's comments on specific issues/quality statements to strengthen the standard:

Quality statement 1: Person – and family – centred care

ACCPA agrees that person-centred care approaches for people from culturally and linguistically diverse backgrounds (CALD) should emphasise the role of cultural belonging. Alternative approaches may be required for people from CALD communities experiencing isolation, loneliness and for those who do not have extended family networks, to support them to be active participants in their care.

Importantly, a large proportion of older people from CALD backgrounds have limited English language proficiency due to limited exposure to formal English language education and some people may revert to their first language as they age.² In this context, ACCPA is pleased to note that the standard acknowledges that "People with cognitive impairment or disability may also lose second languages such as English".

ACCPA supports the suggestion in such cases that: healthcare interpreters should be used; be aware of cultural and communication protocols; and communication boards may be important aid.

¹ Hugo, J. and Mary, G. (2014) Dementia and Cognitive Impairment: Epidemiology, Diagnosis, and Treatment [Clin Geriatr Med. 2014 Aug; 30\(3\): 421–442.](#)

² FECCA [Ageing and aged care.](#)

However, we believe that community leaders should be consulted where appropriate especially when dealing with religious matter.

ACCPA also notes that the term “locally” is used throughout the document to describe indicators. ACCPA believes there is a need for the term to be clarified in the context of each indicator.

Quality Statement 2: Informed Consent

Page 23, Line 33 states “Clinicians”. Whilst ACCPA appreciates the need for consistency, we believe this should specify “Prescribers” as they are the ones who should be talking to the person/family and not the nursing staff. ACCPA is concerned that prescribers may abrogate responsibility if this is left unclear.

Page 24, line 8 Emergency situations states as soon as possible to get consent. We believe there needs to be a timeframe around this as this could be open to interpretation – so within 24 hours would seem reasonable.

The prescriber is primarily responsible for obtaining the informed consent and the aged care provider is responsible for documenting that informed consent was sought and given, for monitoring the resident’s progress and document any changes so the prescriber can make appropriate decisions in the future. ACCPA members have raised concerns that their prescribers were not aware of this responsibility. It is therefore important that this requirement be noted/highlighted in the standard.

Additionally, ACCPA believes the need to periodically re-confirm consent for the use of psychotropic medication, should be considered as part of this standard.

Quality Statement 3: Assessing a person with behaviours of concern

Care for all people living with dementia should cater for each person’s specific physical, emotional and spiritual needs at all times. For people living with dementia and changed behaviours, assess potential unmet needs, and provide non-pharmacological strategies for an adequate and agreed length of time. Assessment of unmet needs and provision of non-pharmacological strategies should be documented in the medical record, behaviour support plan and nursing progress notes where applicable.

Quality Statement 4: Non-drug strategies

The use of individualised, non-pharmacological approaches ideally involves a multidisciplinary team that may include aged care nurses and carers, the resident/family, the GP or Nurse Practitioner, lifestyle officer and possibly other allied health workers. The implementation demands substantial resources, including specially trained staff. Psychotropic medications should only continue alongside non-pharmacological strategies, such as behaviour support plans, with a view to reducing and eliminating the medications if possible.

Quality Statement 5: Behaviour support plans

Prior to prescribing a psychotropic medication to older people with dementia, there should be a comprehensive discussion with that person, support person and/or their substitute decision-maker about possible individual benefits and harms. This discussion should include treatment preferences and be documented in the medical record, behaviour support plan and nursing progress notes where applicable. Treatment preferences should be periodically reassessed.

Importantly, this quality statement should indicate that the prescriber has primary responsibility for the comprehensive discussion about benefits and harms as this discussion is fundamental to obtaining informed consent from the consumer or the substitute decision maker. Consider a re-assessment of treatment preferences quarterly or at intervals of least once every twelve months.

Quality Statement 6: Appropriate reasons for prescribing psychotropic medicine

Page 39, line 14 states that “When medicine is prescribed to be taken on an ‘as required’ (PRN) basis, provide information about why and when the medicine may be used. This includes the reason for use, the minimum interval between doses...” With regard to PRN use, ACCPA believes the reason for use has to be as specific as possible and include any known triggers. For example, “anxiety” is not enough of a description for use as it is open to interpretation/misinterpretation.

Additionally, one ACCPA member noted that even though the pharmacist may have good knowledge about ‘appropriate reasons for prescribing psychotropic medication’, there is a lack of understanding amongst staff about when these medications are appropriate and when they are not. Also, when looking at the indicators for this section, it was not clear regarding what would qualify as a ‘non-drug strategy’ for reporting/monitoring purposes and this needs to be clarified in the document.

Quality Statement 7: Monitoring, review and deprescribing of psychotropic medicines

Quality statement states “A person’s response to psychotropic medicine is regularly monitored and reviewed to identify the benefits and harms of prescribing, and consideration of dose alteration or deprescribing. The results are documented in the person’s healthcare record, along with the timing of the next review.” ACCPA is of the view that the outcome of the review should also be communicated to person where appropriate to support patient-centred care where patient participates in the decision about his/her care.

Quality Statement 8: Information sharing and communication at transfer of care

Transition from one health care sector to another presents an increased risk of medication error and there was a two-fold increase in the relative risk of re-admission associated with the omission of medication from a hospital discharge summary.³ This means, elderly people especially residents of residential aged care, are at particular risk of re-admission and adverse outcomes after hospital discharge. The risk of adverse drug reactions consequently increases which along with medication errors contributes to increased illnesses and high health care costs.⁴

With regard prescribing of psychotropic medicine, however, ACCPA members noted that they have seen on a number of occasions, risperidone prescribed in hospital in an acute setting with little or no documentation about the proposed duration or future plan for use upon discharge. These need to be clarified in the document.

Importantly, general practitioners and pharmacists working with older Australians require accurate medication information to support their ongoing care. To this end ACCPA believes there is a role for LHNs and PHNs to devise collaborative pathways for improving discharge summaries, transfer of

³ Stowasser et al (2002) A Randomised Controlled Trial of Medication Liaison Services—Patient Outcomes Pharmacy Practice and Research Vol 32, Issue 2

⁴ Caleres et al (2018) Elderly at risk in care transitions When discharge summaries are poorly transferred and used –a descriptive study <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3581-0>

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care and communication between hospital-based doctors and a patient's regular GP and the residential aged care facility/home care package provider, ensuring that best practices are implemented.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Roald Versteeg'. The signature is fluid and cursive, written over a faint horizontal line.

Roald Versteeg
General Manager, Policy and Advocacy
Aged & Community Care Providers Association