

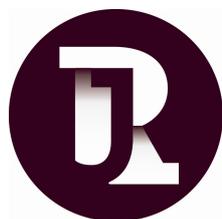
# Review of Authority for Carers to Administer Medication

Section 47A of the Poisons Act 1971

October 2013

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Report



John Ramsay & Associates

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## Executive Summary

In 2009 the Tasmanian *Poisons Act 1971* was amended to enable carers to lawfully administer medications to persons in their care who are unable to administer their own medications. The amendments included the new sections 47A and 47B. Section 47A provides that regulations may be made which prescribe classes of persons who, in appropriate circumstances, may administer medications to another person. This change to the law had several purposes:

- enable carers to legally administer medications where appropriate,
- resolve different interpretations about medication administration by carers, and
- achieve consistency with other states and territories about carers administering medication.

The amendments allow the following groups of carers to administer medications to people in their care when certain requirements are met: school staff; academy staff; polytechnic employees; child carers; foster-parents; aged-care workers in residential aged care services; aged-care workers in community care services; disability service workers, and other carers in specified circumstances.

Section 47B requires that an independent review of the regulations made under section 47A commences within three years. John Ramsay & Associates (the Consultant) were appointed as the independent consultant to undertake the review. A Consultation Paper prepared by the Consultant was released on 5 April 2013; 34 stakeholders were advised. Submissions to the review closed on 3 May 2013. A number of the stakeholders requested additional time to make submissions which was supported. Clarification regarding submissions was sought from a number of stakeholders.

This review found that the section 47A reforms appear to have had a beneficial impact for individuals receiving medication without any reported adverse events. Nine submissions only were made to the review. Submissions state that there have been benefits for continuity of care, care delivery, best use of available skills and career opportunities for extended care assistants.

The overall conclusion is, in light of consideration of the submissions received, that the section 47A reforms have not created broad concerns or implementation issues. There were no submissions received from individuals in care and no submissions that documented harm to a specific recipient of carer-administered medication. While accepting that people in care may not be able or well placed to make a submission, if any issues of concern existed one might expect that relatives or friends would bring their issues to notice.

A smaller number of submissions expressed some concerns about the changes. These concerns include: that the reforms have had a negative impact on skill mix in the workforce in residential aged care; the processes implemented in some organisations for identifying and addressing incidents and adverse events related to medication administration could be improved, and the requirements for implementing the reforms in residential aged care are too onerous and have resulted in limited uptake.

This report covers key issues that are common to all sectors in which carers administer medication and also examines issues that are specific to the individual sectors. While there

are areas which would benefit from further examination, and there are changes that should be made to achieve some improvements to the practices and procedures in some areas, the suggested changes are limited.

The changes enabled by the amendments to the Poisons legislation have achieved their fundamental purpose, albeit that there is still scope for greater adoption of the changes.

The administration of medication however is an area of health practice that requires vigilance in terms of training and the maintenance of the competency of carers, the practice of giving medication to patients/clients/students/children in care, the recording of medication errors and incidents and the examination of the reasons for those events occurring with a view to future prevention. Regulators, peak bodies and professional and employee organisations all have an ongoing role to play in the monitoring of the reforms enabled by section 47A of the Poisons Act.

There are no major recommendations arising from the review, but there are a number of matters that require attention or further consideration these are listed on page 26.

## 1. Introduction

This is a report of an independent review of regulations resulting from 2009 changes to the Tasmanian *Poisons Act 1971* (the Act). The amendments included the new sections 47A and 47B. Section 47A enables carers to lawfully administer medications to persons in their care, who are unable to administer their own medications. The paper:

- explains the legal background to medication administration by carers,
- describes the review process,
- considers the submissions to the review, and
- discusses the review's conclusions about how the new arrangements are working for different groups of carers.

Section 47B requires that an independent review of the regulations made under section 47A commences within three years. John Ramsay & Associates (the Consultant) were appointed as the independent consultant to undertake the review. A Consultation Paper prepared by the Consultant was released on 5 April 2013 and 34 stakeholders advised. Submissions to the review closed on 3 May 2013. A number of the stakeholders requested additional time to make submissions which was supported. Clarification regarding submissions was sought from a number of stakeholders.

In this report, for convenience, the word 'carer' is used in a general way to describe all those persons who are considered to be carers for the purposes of the individual regulations, being disability service workers, school staff, academy staff, polytechnic employees, child carers, foster parents, aged care workers in both residential aged care and community care services and other carers. To determine exactly who is included in these categories, it is necessary to refer to the individual regulations.

## 2. Scope of Review

The review aimed to ensure that the reforms in section 47A of the Act:

- have facilitated continuity in care and medication management, and
- have not resulted in adverse health outcomes.

The scope of the review was to:

- identify observed impacts of regulatory reform, including whether enabling persons to assist others in the medication management of legally supplied scheduled substances has facilitated continuity and timeliness of care,
- seek information on reported incidents and possible adverse outcomes that have resulted from carers assisting in medication administration or administering medication to persons in their care,
- ensure any guidelines required by the regulations are in place, and
- consider any concerns or issues arising from the administration of those guidelines.

The Terms of Reference for the review are at [Attachment 1](#).

### 3. Consultation Process

A consultation paper was issued by the Consultant, that provided a background to the review and identified key questions to assist stakeholders in responding to the review (see [Attachment 2](#)). The consultation paper was published on the Department of Health and Human Services' (DHHS) website for four weeks. Key stakeholders (34) were directly notified about the review process.

Eight submissions were received from organisations together with one individual submission (see [Attachment 3](#)). The Consultant discussed feedback on the review issues with a number of stakeholders.

An overview submission was provided by Aged & Community Services Tasmania (ACST). ACST is the peak organisation for aged care services, community care services and retirement villages in Tasmania. ACST advises that most providers in the State are members of ACST. Submissions were received from Southern Cross Care (Tasmania) Inc and Bapcare Karingal Community. The ACST submission also included the experience of Glenview Community Services introduction of carers administering medication and also feedback from residential aged care facilities that did not change their medication practices.

In addition, as part of their submission, three stakeholders [the Australian Nursing Federation (ANF), National Disability Services Tasmania (NDST) and the Health and Community Services Union (HACSU)] surveyed a subset of their members about their experience with the section 47A reforms.

ANF is Tasmania's largest nursing union and professional body for nurses. Its members are employed in a wide variety of workplaces, private and public, which for the purposes of this review include health and community services and aged care facilities.

ANF comments to the review focus on the operation of regulation 95EA and its application to the residential aged care sector. ANF surveyed its members working in aged care facilities. There were 62 facilities listed, with some organisations running several facilities. Nine facilities reported having extended care assistants (ECAs) administering medications under the authority of regulation 95EA.

ANF reports that the survey process that it conducted was related to those aged care facilities. There were 30 survey responses and a further 39 responses were received through interviews conducted with ANF representatives (nurses and some ECAs); 69 separate facilities were surveyed.

HACSU is the largest trade union in Tasmania representing some 8000 workers state-wide. A significant number of HACSU members are employed in the aged care and disability sectors and are required to administer medications to clients or residents.

HACSU sought comments and feedback from its members by way of a survey. The survey included workers employed in residential group homes, community care, outreach and aged care facilities. A desktop survey was completed over a two week period; 50 members were contacted and all participated in the online survey.

NDST is the peak industry body for non-government disability services. It represents organisations receiving over 90% of state-based funding for disability service provision in the State.

To contribute to the review, NDST sought members' views through face to face forums and electronic distribution of the review material and questions.

The conduct of these surveys is appreciated as it provided an additional source of information for the review, information from those in the care settings and workplaces. The information has been drawn on as part of this report, but it is acknowledged that the information has been obtained in accordance to the methodologies that the organisations chose to apply and on this basis conclusions have not been drawn from the data.

## 4. Background

The Act regulates certain substances and plants, including the sale, supply, use, possession, prescription and administration of medications.

In late 2009, the Act was changed to allow regulations to be made for carers to lawfully administer certain medications to a person in their care who is unable to administer their own medications.

This change to the law had several purposes to:

- enable carers to legally administer medications where appropriate,
- resolve different interpretations about medication administration by carers, and
- achieve consistency with other states and territories about carers administering medication.

The changes allow the following groups of carers to administer medications to people in their care when certain requirements are met:

- School staff
- Academy staff
- Polytechnic employees
- Child carers
- Foster-parents
- Aged-care workers in residential care services
- Aged-care workers in community care services
- Disability service workers
- Other carers in specified circumstances

The amendments to the Act included a requirement for an independent review of the regulations within three years of their commencement.

More background about the changes is at [Attachment 4](#). Extracts from the *Poisons Act 1971* and *Poisons Regulations 2008* are at [Attachment 5](#).

## 5. The legal framework

Two new sections were added to the Act in 2009:

1. Section 47A which enabled regulations to be developed to allow specified poisons or substances to be administered by persons in the circumstances prescribed by the regulations.
2. Section 47B which require the Minister to ensure that an independent review of regulations made under section 47A was undertaken and commenced within three years.

The following regulations were made under section 47A:

1. Administration of certain substances by disability service workers (regulation 95)<sup>1</sup>
2. Administration of certain substances by school staff (regulation 95A)
3. Administration of certain substances by Academy staff (regulation 95B)
4. Administration of certain substances by Polytechnic employees (regulation 95C)
5. Administration of certain substances by child carers etc (regulation 95D)
6. Administration of certain substances by foster-parents (regulation 95E)
7. Administration of certain substances by aged-care workers in residential care services (regulation 95EA)
8. Administration of certain substances by aged-care workers in community care services (regulation 95F)
9. Administration of certain substances by carers (regulation 95G).

The regulations specify:

- who can administer a medication,
- to whom the medication can be administered,
- requirements about the range of medications that may legally be administered, and
- the conditions under which the administration can occur, including references to any guidelines that apply.

In most cases, each regulation also requires that the administration must be in accordance with particular guidelines.

The regulations specify that the guidelines for administration of certain substances by school staff, Academy staff, Polytechnic employees and child carers must include the following:

- the form or method of authorisation for administration that is to be given by a parent or specific health practitioner,
- storage and recording requirements for the substances that can be administered,
- protocols for the administration orally, subcutaneously or by any other means,
- protocols for dealing with narcotics specified in Schedule 8 to the Poisons List, and
- information on the appropriate disposal of an unused substance.

An overview of medication administration by specific groups of carers is at [Attachment 6](#).

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<sup>1</sup> **Note** regulation 95 pertaining to disability service workers was made in 2002. Disability workers with appropriate training were allowed to administer schedule 2, 3 and 4 medications in accordance with guidelines. However, regulation 95 was amended in 2009 to enable disability workers to administer psycho-stimulants and "specified narcotic substances".

A summary of the requirements for different types of medication is at [Attachment 7](#).

An overview of the authorisation framework is at [Attachment 8](#).

## 6. Key general reform issues

### Quality and Continuity of Care

The information provided to the review indicates that the reforms have had a beneficial effect in relation to the quality and continuity of care available to medication recipients.

NDST members report that the changes brought about by the 47A reforms have largely improved the effective care of disability service clients with medication support needs. This is due to improved quality of life due to timely and safe administration of medications.

The Education Department reports that the appropriate school staff's ability to administer medication for students assists both the individual students and their families.

For students who require medication for ADD/ADHD at specific times of the day, the Department observes that the school setting enables a consistent approach to be taken. This is important for the student as the effectiveness of the treatment is continued and the results of improved concentration and behaviour are positive for learning and relationships within the school setting.

The Department also observes that many parents have difficulties with medication administration throughout the day for a range of reasons. Knowing that the school administers medication in a supervised and managed way provides parents with a level of confidence around managing the health needs of their child.

In the residential aged care services sector, two providers identified positive impacts of the reforms. They both indicate that continuity of care has been improved and the following benefits are noted:

- The changing focus of resident acuity is that generally residents are entering aged care at a later stage of ill health and disability and require more complex care. Extended Care Assistant (ECAs) being able to deliver medications to health stable residents, has meant that valuable Registered Nurse (RN) and Enrolled Nurse (EN) time has been freed up to give more focus to the assessment and provision of complex care.
- ECAs have a greater care knowledge of residents because they are involved with other aspects of care provision for the same group of residents. This leads to a deeper understanding of their personhood.
- More effective care practices have been realised as the medication rounds are smaller, meaning that medications are given on time.
- Time management is optimised as ECAs administering medications use a 'do not disturb policy' which means that they are subject to much less disruptions than an EN or RN who often get called away when administering medication to attend phone calls, acute care needs, doctor visits, family concerns, resident requests etc.
- The new system has allowed for greater skill use in areas of best need.

- A longer working life has been created for ECAs as a medication administration role is less demanding. It has taken them away from more physical work such as showering and personal care.
- ENs medication load has been reduced allowing more time for other clinical care.

One residential aged care service provider indicated that there has been minimal impact on the effectiveness of continuity of care because the administration of medication has always been undertaken by both RNs and ENs. Further, robust monitoring of medication management and resident lifestyle quality through continuous improvement systems is a longstanding feature of residential aged care.

The survey responses from the HACSU members indicate that 56% of the respondents considered that the ability to administer medications had been advantageous to carers and clients as follows:

- easier for clients day to day process,
- less stress on clients who cannot self administer,
- clients receive regular medications, and
- clients feel a greater autonomy in their lives.

Of the members who responded to the HACSU survey 21% were unsure if there had been a benefit or not and 23% stated that they felt that there was no benefit (although HACSU notes that some of the staff surveyed were not required to administer medication in the workplace).

Of the HACSU members who responded 68% stated that support worker/ECA's administering medications assisted clients in maintaining a better quality of life. This includes the ability to access specialist care whether in the home or being able to travel to appointments and giving clients more freedom to spend time with family or access respite if required. 19% of members did not notice any change.

Most of the HACSU members surveyed stated that administering medication had been a positive step forward for a number of reasons including assisting to give clients a better quality of life and an overall feeling of more autonomy.

### **Adverse Events**

The responses to the review indicated that there was no information or advice from any sector in relation to a client/patient suffering an adverse health event as a result of receiving medications from carers under the section 47A reforms.

While not reporting any adverse events, the ANF observes that its survey results indicate that only 50% of facilities have medication committees to formally review potential or actual adverse health outcomes. The AMA reported that in some organisations systems were not in place for reviewing medication errors to prevent reoccurrence.

The ANF reported that potential adverse health outcomes have been identified where changes are made to the medication regime on a patient/client chart but not altered on MedSig (the online paperless system for aged care facilities). The ANF also advise that there is no ability to report incidents through emergency admissions as no coding is in place to identify admissions through drug errors from the disability or aged care sectors.

Similarly ANF advises that there is no ability to report matters to the Australian Health Practitioner Regulation Agency as ECAs are not regulated and therefore any significant issues can only result in termination of employment and then reemployment elsewhere. The ANF contrasts this with the situation of nurses who may have sanctions placed on their practice and are subject to national notification.

Notwithstanding the ANF observations about the reporting processes and systems, no information was provided to the review in relation to adverse events.

### **Medication Practices, Procedures and Reporting**

The ability of carers to administer medication has clearly resulted in a focus on training, supervision and revised or additional practices and procedures designed to avoid any medication errors or incidents and should they occur, to accurately record them.

NDST advises that their members have service agreements with DHHS containing quality and safety reporting mechanisms that include reporting any medication incidents.

Medication audits and PRN counts are in place to ensure accurate administration and identification of errors. All medications are checked on collection from the pharmacist to ensure correct packaging. NDST members stated that there is rigorous reporting of errors to identify opportunities for continuous improvement.

The AMA reported that in community based disability services there were some inconsistencies in the way the guidelines had been implemented. These included: varying medication charting requirements and limited systems for reviewing medication errors. The AMA observed in some instances unnecessary medication charting requirements resulted in some patients attending medical appointments where they were not required; The AMA also reported that where patients required more complex medication regimes and nursing staff were not readily available medical practitioners were required to modify their prescribing practices or patients were required to attend their surgeries.

While no adverse events were reported from the three residential aged care providers who responded to the review, advice was that there has been an increase in the documented medication errors. ACST confirm an increase in the reporting of medication incidents in the residential aged care sector. This is attributed to all errors now being reported. It is suggested by ACST that in the past it is likely that nurses did not accurately report all errors as they made a professional judgement at the time and only reported those errors they determined would adversely affect the resident.

Further, ACST suggest that pharmacy errors are being reported more, as again in the past nurses identified and fixed the errors with the pharmacy and did not formally report them. ACST advise that the benefit of more accurate reporting of medication errors is that providers are working with pharmacists to resolve the errors.

The reporting of “finding” medications in residents’ rooms is also considered beneficial as it prompts discussion on new ways to deliver medication following collaborative discussions between RNs and ECAs.

Provider residential aged care submissions to the review indicate that systems exist to report and review any medication errors. Systems include immediate reporting to RNs, completion

of incident report or medication error forms, incident investigation to determine root cause, and reports to monthly quality meetings.

The review of the incident or error can result in a requirement to redo the annual competency check, further training, or the removal of the carer from medication responsibilities until further training is complete and competencies reassessed, as required by the circumstances.

It is reported that one provider has systems in place to identify any errors or omissions, which involves the doctor and the pharmacist reviewing medications, and another provider has a medication error procedure to inform the resident's General Practitioner.

Child and Youth Services (CYS) advise that a 2012 audit of Complaint in Care notifications by their Quality Improvement and Workforce Development Unit showed that there had been no regular or major concerns in relation to medication management or compliance. Although the formal foster care review process does not specifically refer to compliance with the medication policy, CYS advises that local Out of Home Care teams have been establishing strategies to ensure that this is reviewed with the aim of formalising it within foster care reviews in future.

The Foster Carers Association was not aware of any incidents in relation to medication administration, but commented that carers are not as closely supervised as staff in institutions, the inference being that incidents may not be disclosed or recorded. The Association was also not aware of the monitoring of medication charts.

Information from the HACSU survey indicates that 28% of survey respondents stated that there had been errors when administering medication. Some examples given were medication given to the wrong client, medication missed or a double dose given, medication found on the floor and not being able to be identified when the dose was missed, and medication charts not being signed correctly.

HACSU further advise that recording and reporting medication errors varied between the employer and the industry. Employees provided a number of responses being, communication book report to, or notifying the supervisor, medication error forms, incident reports, reporting errors in the case notes, reporting to the RN, calling GP Assist or the poisons hotline.

Members of the Pharmacy Guild of Tasmania advised of issues that have arisen as a result of the establishment of the guidelines. The Pharmacy Guild advised that there is a lack of consistency in the implementation of the guidelines between similar facilities. Their view is that this has resulted from the adoption of rigid protocols which clarify the procedures for carers, but because of their bureaucratic nature and inflexibility, make large demands on community pharmacy and increase costs and workload.

The Pharmacy Guild considers that compliance and monitoring protocols have been developed by facilities through their desire to adhere closely to the guidelines. On occasions this has resulted in facility staff making what pharmacists believe are unreasonable or unsafe requests for assistance or alterations to documentation. The Pharmacy Guild advises that these requests do not appear to relate to a requirement to meet any legal or ethical obligation, but in order to demonstrate compliance with facility administrative practice. These

are not documents that pharmacists have any responsibility for or are within the authorised activities of pharmacists.

A further issue concerns after hours pharmacists, who have been asked on occasions to deal with matters concerning medications when they are not the dispensing pharmacy. They are not authorised to deal with such matters as they have no prescribing advice from a doctor. While pharmacists endeavour to assist, at best they can only provide common sense advice. The Pharmacy Guild suggests that these issues may arise because of a change of the role of the RN in some organisations.

Finally, the Pharmacy Guild observes that there is extensive reference in the guidelines to consulting the intentions of the prescriber, but there seems to be little recognition of the role of the professional pharmacist and of their ability to provide authoritative advice on the handling of prescribed medicines.

While the Pharmacy Guild does not argue against the intent of the reforms, they indicate that there have been consequences for the practice of community pharmacy.

The Pharmacy Guild suggests that it would be appropriate for facilities to consult with the pharmacies supplying the facility on the appropriateness of procedures and documentation such as signing sheets, before procedures are signed off for implementation. This would facilitate the professional role of a pharmacist to interpret the clinical aims of the treating medical practitioner and to give guidance to the facility staff on the Quality Use of Medicines. The AMA also suggested medical practitioners should be consulted about the appropriateness of procedures and documentation; particularly requirements for completing drug charts.

## **Training**

Given that for many carers, the ability to administer medication was a new responsibility, training to discharge that responsibility was an essential critical element of the effective implementation of the section 47A reforms.

In the disability sector, as medication guidelines had been in place previously, NDST member organisations already had policies and procedures in place and no major training initiative was required. However disability service organisations engaged with training industry providers to ensure that the new guidelines were reflected in core competency training including strengthening of relevant qualifications. Where appropriate, NDST advised that their member organisations reviewed and updated internal processes to ensure both the currency and adequacy of staff competency, which is now standard industry practice.

No employees in disability organisations are permitted to administer medications until core competency training has been completed and staff are deemed to be competent. NDST advised that the industry has adopted rigorous induction processes for new staff that include clear information on medication administration and the current guidelines being available at appropriate sites where medications are administered. Employees' comprehension of the guidelines is tested as part of site orientation and regular training. Some disability support workers are employed without the medication administration qualification, as many clients in the community are self-medicating. However members consider it preferable that all workers hold the qualification and they are supported to attain it.

The Education Department advised that members of staff who agree to administer medication for a number of the health issues identified in the procedure guidelines must be appropriately trained and credentialed, as required by the guidelines. All schools are encouraged to keep training records on site and the Department's internal audit branch undertakes a check and review of all school records.

To provide training to foster carers, the Pharmacy Guild as a consultant to CYS, through trained pharmacists, conducted 20 seminars across the State to advise foster carers of the new requirements when administering medications to children in care. It was intended that this training would be incorporated into the existing training arrangements for new foster carers but CYS advise that this has not progressed.

The Foster Carers Association confirmed that after the initial training there has been no further training and that not all foster carers in the State have undertaken medication training. CYS advised that they still intend to include the medication training in the Shared Stories Shared Lives training that is provided to new foster carers.

Notwithstanding the absence of the formal training, CYS advise that medication management policies for foster carers are available on the DHHS and Foster Carers Association websites. They also advise that the foster carer's handbook provided to all new foster carers, references these policies. However CYS recognises the ongoing need to include medication training as part of the training for new foster carers and this should be implemented as soon as possible.

In the residential aged care sector, one provider which moved to implement the changes available by the reforms, indicated that existing carers were offered training via an expression of interest to work in the program and carers who attended an accredited medication training program, were assessed for competency and provided with a full orientation to the medication program. Further they advised that the medication program is regularly audited for safety and effectiveness, staff are updated on any changes, competencies are checked on an annual basis, incidents are reviewed for root cause and specific education programs are run if required.

A second provider advised that training was and is provided through a Registered Training Organisation (RTO) for all carers. Carers administering medication have increased their qualifications. They must have at least the relevant Certificate III before undertaking medication training. The training is in all nationally accredited modules relating to the administration and storage of medication and (if not previously completed), recognising healthy body systems. All trained carers who are trained in medication have an annual competency check undertaken by an RN using an assessment form that has been written with an RTO.

ACST observed that the key to new systems such as the section 47A processes is effective workforce development involving quality training and support. It suggests that it may be appropriate for any guidelines to strongly encourage service providers to ensure RTOs are being used so that quality of practice across the sector is protected. The information received from the ANF in relation to the residential aged care sector was that training is reported as being inconsistent with some respondents to the ANF survey indicating that training and evaluation is "on the job". ANF indicated that some facilities reported that there are annual assessments undertaken on site by the RN.

HACSU have members who work in both the aged care and disability sectors. The information indicated that 58% of members surveyed had completed some kind of medication training, followed up by refresher courses, while 36% stated this was not applicable as they didn't have a medication management role. Those members who had completed the training stated that they had completed either a two or three day course with a refresher to be completed every three years.

However the survey reported that the training in the workplace was vastly different between employers, some workplaces having in house systems such as buddy or a check list, while other employers have none. The workers in both the aged care and disability sectors consider that there needs to be more consistency to the ongoing training of staff so that they are able to transition from one employer to another without being disadvantaged.

Standardised and uniform training across the industries was identified by HACSU as the most important issue. As workers often have more than one employer, differences in training and guidelines between workplaces are confusing and create potentially unsafe work practices.

## **Supervision**

Supervision of the administration of medication by carers was an issue for discussion at the time of the introduction of the section 47A reforms.

In the disability sector, NDST members reported some variation across the sector in relation to supervision procedures. The supervision depends primarily on the service setting and the number of staff on the shift at the relevant time.

NDST advised that many organisations have procedures in place that stipulate that where two people are on a shift, one staff member administers the medication and one monitors the process to avoid errors, using the 5Rs checking process. Where a staff member is on a shift alone, organisations report that they have processes to require 'double checking' by that staff member.

In the residential aged care sector, providers report that the responsibility for managing medication remains with the RN and the RNs are aware of their responsibilities. A RN is on site and in close contact with the ECAs. One provider indicated that the Director of Nursing and Nurse Unit Managers also provide direct and indirect supervision. Carers are required to immediately report any changes or issues that are identified. Medication charts are audited on a regular basis and reviewed by the doctor and the pharmacist on a regular basis.

The ANF reported that RNs have additional responsibility for supervising the actions of ECAs related to medication administration. This was not a requirement of RNs when ENs were administering medications.

Additionally ANF advise that assessment of ECA competency falls to RNs in many facilities. This is said to have the potential to overload RNs and several commented in the ANF survey response that there is not enough time to adequately supervise ECAs.

Further it was reported that there has been a lack of consultation with staff prior to changes and no consultation process was apparent in some facilities. Some survey responses

indicated a need to introduce an electronic medication system prior to delegating this important role.

The HACSU survey indicated that supervision was different between worksites and industries. Examples of supervision reported were audits of medication and charts at shift change, supervision by an RN, co-signing where two people check the dosage, co-ordinators are on the premises to supervise medication administration.

### **Skill Mix**

A potential change as a result of the section 47A reforms was a change to the skill mix of the staff providing care in institutions, because carers have authority to administer medication, and the staff which previously had that responsibility are able to undertake different roles.

In the disability sector, it is reported that no marked change has been noted in skill mix of employees in individual organisations.

The area of institutional care in which there was potentially the greatest skill mix change was the residential aged care sector. In this sector a range of responses were received in relation to the issue of skill mix as follows:

- the RN role has become more diverse and interesting and so is more attractive to nurses,
- RNs have benefitted from the change by now being able to concentrate on resident areas,
- skills realignment has enabled staff with professional nursing skills and knowledge to use these more effectively for better outcomes for residents, rather than spending time on tasks that can be done by ECAs who have specific training,
- because the care worker role is more interesting, more nursing students are attending for work experience, which has been beneficial for recruitment
- carers have benefitted by having another career pathway option, there is a new area of skill development and diversity in the carer role,
- there are now two tiers of aged care worker, those who administer medication and those who don't, and
- there has been a reduction in ENs in organisations where the changes have been implemented as a direct consequence of the guidelines stipulating that an RN must be in the building at all times when workers are administering medication.

The ANF reported that medicating ECAs have replaced both EN and RN positions in aged care, further diluting the skill mix. The percentage of ECAs with medication endorsement was not known, but some survey respondents report that it may be as high as 70% in facilities where ECAs administered medication. Only 50% of RNs considered that they had time for other duties as a result of the changes. ECAs are reported to have increased workloads and many do not want to take on extra responsibility.

HACSU reported that the view from the members who responded to the survey is that the skill mix in the workplace has improved and that that aids them in their roles as support workers or carers. Because of their medication training the workers consider that they are able to identify adverse effects that medications can cause for example with client

behaviours. Workers now consider clients from a more holistic point of view, whereas previously adverse effects of medication were not an issue that some workers accounted for.

### **Consistency of Guidelines Across all Sectors**

The aged care residential services sector questioned why the various carer sectors covered by the respective regulations are treated differently in similar circumstances, ie the provision of medication. The aged care sector cites the example of the worker categories administering medication to children or students in the education sector. The guidelines are produced by non-health professionals, and workers do not require guideline specified training or competency assessment, initial or annual re-assessment. Further, workers administering medication in the education sector are not supervised by nurses.

This is compared to the more detailed and much stricter requirements for the residential aged care sector, which is already highly regulated and supervised because of Australian Government requirements.

There is a view that there should be consistent training and competency assessment required for all categories of worker under s.47 regulations with the possible exception of regulation 95G. The residential aged care sector considers it appropriate for DHHS to have an overarching role in terms of best practice and compliance.

#### **Comment**

It is correct that the section 47A regulation requirements vary for different categories of carers. However, this reflects the different circumstances and characteristics of those receiving medication. The current variation between the guidelines is appropriate given the differing content of the respective regulations and carer roles and the circumstances in which people are receiving medication.

The provision of medication to otherwise healthy children in the education sector in school hours, is completely different to the provision of medication to persons in long term institutional care who are elderly and who might have complex health issues which require various treatments and a range of medications.

The development, ongoing review and oversight of the regulations as they apply to different circumstances of the provision of medications to clients/patients/minors is appropriately undertaken by those regulatory agencies that are responsible for that sector. It is however important for all regulatory bodies to take advice from experienced health professionals in the appropriate disciplines in the discharge of their responsibilities.

## 7. Implementation Practice and Specific Carer Group Issues

### Disability Service Workers (Regulation 95)

#### *Guidelines and Procedures*

*Guidelines for the Administration of Medication for People with Disability Receiving Community Based Disability Services* commenced on 1 July 2010. These guidelines replaced similar guidelines that had been established in July 2008. The organisation responsible for the guidelines is Disability, Housing and Community Services in the DHHS.

NDST considers that the current policy and guidelines are adequate in providing guidance to service providers regarding their role in the administration and management of medication as well as ensuring that client safety and quality health care is not compromised.

As far as the guidelines allow, NDST considers that the protocols allow providers sufficient scope to establish informed policies and procedures consistent with the intent of the guidelines. The guidelines are readily available and relatively easy to interpret.

#### *Issues arising from administration of the Guidelines*

It is reported that the tightening of the regulatory requirements in this area of practice has led to staff working more closely with clients. However due to resourcing implications, the sector has advised that staff are now less able to provide other forms of support in their day to day support of individuals.

#### Schedule 8 Drugs – Poisons List

Many NDST members reported that they wished to see responsible and appropriate changes to regulation 95 to include all Schedule 8 drugs on the Poisons List. They argue that this will lead to better quality of life outcomes for individuals, particularly those in palliative care arrangements. They advise that there are generally quite a few new people in a person's life at this time and service providers argue that continuity of care is affected with the need for an additional person just to administer Schedule 8 medications.

A further problem has arisen for consumers and clients where additional medications are prescribed for breakthrough pain but providers experience difficulty in accessing a community nurse to attend the site to administer the medication when it is needed. Providers consider that this also increases their administrative burden and directs support time and resources away from consumers.

#### *Comment*

Resolving the need to include all Schedule 8 drugs within the scope of regulation 95 is beyond scope of this review. If this issue is to be pursued, a separate process would be the best approach to enable the merits of such reforms and any system safeguards to be carefully considered by the relevant care providers, clinicians and regulators.

## **School & Academy Staff, Polytechnic Employees (Regulations 95A-95C)**

### *Guidelines and Procedures*

The Department of Education have established a series of guidelines to support the implementation of the Regulations. The guidelines are:

- Procedures for Specific Health Issues
- Procedures for Administration of Medication
- Guidelines for Administration of Medication

As part of the Administration of Medication Procedures, specific authorisation forms have been developed which must be completed by parents or guardians, and doctors, pharmacists and practice nurses as appropriate. The guidelines and the forms are all accessible on the internet.

### *Issues arising from administration of the Guidelines*

The Department reported the following issues for some schools and child care services in relation to the administration of medication:

- staff feeling confident with their skill level,
- dealing with students who are difficult in terms of their behaviour and who can be reluctant to take or accept their medication,
- working with families who are not always reliable in providing medication when it is required,
- time, in terms of administration of medication, particularly for those schools that may be required to manage the distribution of medication over a weekend where the school has a responsibility for the collection, management and storage of the medication,
- for some smaller schools, it can be difficult to have sufficient staff available at certain times to provide medication and care, and
- for some schools there can be a significant impact due to the number of students requiring medication at a number of different times during the day.

### *Comment*

The documented procedures established by the Department indicate a comprehensive approach to managing medication administration. Many of the issues identified will be ongoing requiring management simply because of the circumstances in which staff are administering medication to students or children in their care.

## **Child Carers (Regulation 95D)**

### *Guidelines and Procedures*

The Department of Education have *Guidelines for administration of Medication in Education and Care Services*. Medication storage and administration is covered in the Tasmanian *Licensing Standards for Centre Based Child Care Class 4 and Class 5*.

### *Issues arising from administration of the Guidelines*

The Department's response to the review raised two issues in relation to the administration of the guidelines for child carers. The issues were the consistency of approach in child care services and the consistency of training in child care services.

#### *Comment*

Legislation and standards regulate the provision of child care services. If the Department of Education has ongoing concerns about the matters that it has highlighted to the review, then there is no doubt scope for it to take appropriate action within the existing regulatory framework for the provision of child care.

### **Foster Parents (Regulation 95E)**

#### *Guidelines and Procedures*

CYS within the DHHS have responsibility for establishing and administering the guidelines and procedures in relation to foster carers. Following a consultation process with key stakeholders, Departmental guidelines for foster carers were established in April 2010. The guidelines are comprehensive and were initially available on the internet.

While the April 2010 guidelines may have been initially available on the DHHS website, a search indicated that at the time of the search they were no longer accessible. There is a limited reference to administration of medication in the 2009 edition of the *Carers Handbook*, which refers the foster carer to the DHHS's medication policy. However it is not always possible for all carers to access documents on the website and it would be appropriate to provide all carers with a hard copy of the medication guidelines.

The main change in practice for foster carers in implementing the guidelines, included the following:

- narcotic medication to be stored in a separate lockable box,
- a medication register to be kept and signed for all medications (including non-prescription medications, vitamins and panadol etc), and
- a separate medication register for narcotic medication which includes a running balance of how much narcotic is given and how much is left in the packet/bottle.

CYS advise that the home environment for a foster child is assessed by a Child Protection Worker to ensure that there are adequate medication storage facilities and that the carers are aware of the requirements for, and are capable of safely administering medications. Medication register pages are returned to Child Protection Services for filing when they have been completed.

### *Issues arising from administration of the Guidelines*

Initial feedback on the guidelines indicated that foster carers were generally supportive of the controls surrounding narcotic medication as it kept medication separate and more secure within the household.

The requirement for a register for all other medications (especially non-prescription) was viewed as overly onerous for carers of children who do not have complex medical needs.

Feedback was to the effect that this 'singles out' children in care and makes them different to other children in the household. It was also said to be inconsistent with normal parenting practices causing confusion if a child is undergoing reunification with their biological parents as they are not required to undertake such documenting practices.

#### Kinship Carers

CYS has raised the issue of whether the legislative requirements include kinship carers who provide care to children under the guardianship of the state, but who are not 'foster carers' or 'foster parents'.

#### *Comment*

The question of whether regulation 95E applies to 'kinship carers' is a matter that CYS should resolve in light of legal advice. Children or young persons in 'formal' kinship care have been placed in care under the provision of the *Children, Young Persons and Their Families Act 1997*, and as such the DHHS has responsibility for those children. While there may be an issue about the wording of regulation 95E referring only to foster parents, it is noted that the guidelines cover medication management for children and young people in out of home care and include references to kinship care placements. When the policy considerations are resolved about 'formal' and other kinship care and the application of regulation 95E to those carers, if a change is required, the regulation could be simply amended to include appropriate definitions in regulation 95E, similar to the other regulations.

While a range of issues have been identified by CYS, the service is clearly aware of its responsibilities, and is able to resolve these issues consistent with the ongoing support and oversight that they provide to foster carers.

### **Aged Care Workers in Residential Care Services (Regulation 95EA)**

#### *Guidelines and Procedures*

Following a consultation process with key stakeholders, the DHHS produced comprehensive guidelines for the 'Administration of certain substances by aged-care workers in residential aged care services'. The guidelines were approved by the Secretary, DHHS on 2 August 2010 and have a publication date of 1 September 2010.

The guidelines are comprehensive and outline the roles of the Approved Provider, aged-care workers, RNs and ENs. They also detail education and competency requirements; the administration of buprenorphine; PRN, stat and once only medication requirements; medication administration record requirements and matters associated with medication ordered by telephone. They include a Poisons Schedule Summary and a section on the Principles of Safe Administration of Medication.

#### Access

It is reported that initially the guidelines were difficult to access as they were only available on the DHHS intranet. ACST provided electronic copies of the guidelines to its staff initially but the guidelines can now be accessed via Google search, and are provided on organisation intranets. Hard copies are also provided to carers.

## Content and Length

The guidelines are considered to be adequate although with scope for refinements. The sector views on the current guidelines are:

- overly detailed with superfluous information such as defining the role of the aged care worker,
- need for the level of detail is queried when workers administering medication in the residential aged care sector are the most supervised and regulated of all worker categories covered under section 47A,
- lengthy, which could discourage staff from reading them carefully, and
- Principles of Safe Administration at Section 5 could be removed, as all staff administering medication must have relevant qualifications and the principles are at the basis of all medication administration competencies.

One aged care provider argued that the guidelines for residential aged care are too prescriptive. This provider noted that residential aged care workers are supervised by nurses compared to those administering medication in the education sector, who do not require specified training or competency assessment and are not supervised by health practitioners.

## Qualifications Specification

The guidelines cite specific requirements in clause 3.5, naming individual Certificate III qualifications and competency units that were current at August 2010. ACST point out that these units are reviewed and are frequently updated and the names of the units change. The effect is that the guidelines go out of date. ASCT suggests that the wording of clause 3.5 of the guidelines be changed to reflect this and to be consistent with r. 95EA (2)(a)(iii).

## *Issues arising from administration of the Guidelines*

The ANF continues to have concerns with unregulated workers administering medications in all settings, but considers that regulation 95EA (aged care workers in residential care), presents the highest risk to public safety. This is because aged care residents have a higher complexity of co-morbidities and palliation and therefore more complex drug regimes.

Given the reform, the ANF welcomed the guidelines made under regulation 95EA as the 'guiding document binding Residential Aged Care Providers to maintain accountable practice in relation to the role of the aged care worker'. The ANF fully supports the continuation of the guidelines.

## Registered Nurse on site Requirement

The ANF has indicated that the pivotal statement in the guidelines which it is essential to maintain is:

*"where an aged carer worker has been assigned to administer medication the registered nurse must be on site and accessible at all times for ensuring the safe administration of medication to residents"*

The ANF maintain significant concerns that the ECAs did not have the depth of knowledge of medications required, ie actions, knowledge of adverse events, interactions, timing and

recognition of normal or abnormal doses. It was also reported that ECAs sign for the number of medications they administered, not the individual medications.

From the ANFs perspective, their survey outcomes indicate shortcomings in the aged care systems operating under the current guidelines and potential risks in relation to adverse events and potential overload in the work of RNs.

ACST reports that the requirement that an RN be on site when ECAs are administering medication is a concern for some facilities. As there have been no adverse health effects as a result of the medication administration under the guidelines, ACST suggests that to have an RN on site is not necessary. The ACST suggest that an EN on site with an RN available would be sufficient to ensure appropriate oversight of medication administration.

While ACST indicates that many facilities will continue to have an RN on site, it states that there needs to be flexibility in staffing so providers can innovate, introduce new systems and respond to local circumstances. An example given is that a small provider who struggles to recruit nurses and cover leave and who has two facilities close together should have the ability to have an RN accessible to both facilities but not on each site.

#### Recognition of Prior Learning

One submission suggested the recognition of prior learning for staff who work as ECAs and have completed the University of Tasmania Bachelor of Nursing module on Medication Management, with a view to enabling those staff to administer medications.

#### Limited Change in Medication Administration Practice as a result of the Reforms

ACST reports that the medication administration reforms enabled by section 47A have had limited uptake in the residential aged care sector and there has not been widespread change. Only around five per cent of residential care facilities have moved to a system of paid carers administering medications. There are 78 accredited residential aged care facilities in Tasmania and based on ACST information there are three maybe four sites who have implemented reforms. This contrasts with the ANF advice that nine sites have moved to use ECAs. Whatever the actual number, it is clear that the uptake of the opportunity to administer medication has been limited.

From the perspective of ACST, there are a number of suggested reasons for this, as outlined below:

- During the reform process, many stakeholders outside the residential aged care sector had a view on what should not happen and what the intentions of the sector were in terms of eliminating nurses from the sector and establishing poor practice.
- The response of nurses from other sectors, including the acute sector, in voicing their opposition to the reform proposals was seen as an attack on aged care professionals. This resulted in a difficult environment for aged care clinical leaders to consider and lead change because of concern over their reputation and standing in the broader Tasmanian health care community.
- The influence of the DHHS facilities which deliver aged care in rural areas with operational models that include acute and emergency services, perceivably opposing the changes was a factor. This did not take account of the fact that the

model of care in those facilities is different in terms of staffing profile to non-government residential aged care.

- Lack of recognition of the changes to how medicines are dispensed with the introductions of pre-packed and dispensed controlled dosage packages, and that under controlled conditions such as provided by the guidelines it would be appropriate to consider a change in workplace practice.
- The shortage of aged care nurses across the state is not uniform so in some areas a need for change was not seen.
- Lack of faith in the registered training organisation system to provide quality training and support.
- A concern for the aged care staff in an already underfunded sector that the changes would cause additional stress, workload and erode key roles.

Feedback from residential care facilities that did not change practice as a result of the reforms includes the following:

- No requirement to change as there is currently no shortage of RNs or ENs.
- Current staffing and practices do not involve an RN being “on site and accessible at all times” as required by the guidelines. An RN was on call at all times and there were many times when an EN was on site rather than an RN.
- Perception that the RN would retain accountability for the administration of medications by the carer and this would add to the RN’s workload and diminish and erode the role of the EN.
- Medication administration by nursing staff provides an opportunity for assessment of all residents and recognition of changes in health status.
- High training costs to train the carer.
- The need for additional literacy and numeracy support for those carers from CALD backgrounds.
- No expressed interest from carers in taking up the role.

#### *Comment*

The implementation of the changes enabled by the section 47A reforms and the issue of the guidelines for the residential aged care sector has clearly been varied and apparently limited.

The section 47A reforms are enabling reforms. It is a matter for providers to adopt them as they consider appropriate to the model of care that they wish to provide to residents, the additional time and resources that they are prepared to invest in a new model of care, and indeed the willingness of staff to secure the necessary qualification to enable them to administer medication.

From the information received from ASCT and providers who have decided to change their practices and procedures as a result of the reforms, and to invest the necessary resources, it is apparent that the changes can operate effectively and safely. While there is greater reporting of medication errors, no adverse events have been reported. The reporting of the medication errors is said to result from the greater scrutiny of medication administration that takes place under the reform requirements.

The sector through ACST is however advocating a significant additional reform, and that is that the removal of the requirement to have an RN on the site when a carer is administering medication. The sector suggests that having an EN on site and an RN always available would be sufficient to ensure appropriate oversight of medication administration.

It is clearly beyond the scope of this review to recommend such a change to the guidelines. A more detailed study of the merits of any such change would need to be undertaken by the relevant regulators in consultation with the residential aged care sector and the appropriate professional and employee organisations.

A factor in considering any further review in the near future is the limited number of residential aged care providers that have moved to implement changed medication practice arrangements that are enabled by the section 47A reforms. Experience of a greater number of providers in application of the model would provide a more substantial information base on which to consider any such reforms.

### **Aged Care Workers in Community Care Services (Regulation 95F)**

#### *Guidelines and Procedures*

Regulation 95F does not require compliance with any guidelines.

Only limited information was provided to the review in relation to aged care workers in community care services.

In its submission ACST is of the view that this will be an area of huge growth in aged care and services in the future. ACST observes that this area was not a key focus during the debate on the section 47A changes, despite the fact that the number of high care aged clients in the community has increased.

ACST advises that it has responded to the need to provide guidance to community care providers in this area. It brought together the sector clinical leaders and has produced a document titled "Recommendations on the Administration of Specified Medication by Aged-Care Workers in a Community Setting" dated June 2012.

As the document indicates, it has been developed using the DHHS guidelines for residential aged care as a point of reference and it has been produced with a similar structure to the DHHS document. Similar to its view in relation to residential aged care ACST considers that the RN supervision requirements in the 'Recommendation document' should be replaced by reference to a nurse.

Similar to the situation that exists with residential aged care in relation to existing accreditation standards applying to that sector, there are community quality care standards established by the Australian Government.

## 8. Conclusions

The overall conclusion is, in light of consideration of the submissions received, that the section 47A reforms have not created broad concerns or implementation issues. There were no submissions received from individuals in care and no submissions that documented harm to a specific recipient of carer administered medication. While accepting that people in care may not be able or well placed to make a submission, if any issues of concern existed one might expect that relatives or friends would bring their issues to notice.

Most submissions did not address all the review questions but focussed on specific issues.

A small number of submissions express concern about the section 47A reforms. The concerns are:

- that the reforms have had a negative impact on skill mix,
- the processes for identifying and addressing adverse events related to medication administration are inadequate in some organisations, and
- the requirements for implementing the reforms in residential aged care are too onerous and have resulted in limited uptake.

Furthermore there is information that indicates that there is an increase in the reporting of medication incidents and errors, but this can possibly be attributed to the greater focus on incident reporting systems and the documentation of incidents as a result of implementing the reforms, in accordance with the requirements specified in the regulations and the requisite guidelines.

The scope of this review did not include the independent investigation of some of the matters raised, or indeed a review of all the practices and procedures of the organisations that have implemented the reforms, so there is no independent conclusion about what staffing or other practices may have been adopted by organisations. Furthermore, whilst data from surveys undertaken by some organisations who provided submissions has been drawn on as part of this report, it is acknowledged that the information has been obtained in accordance with the methodologies these organisations chose to apply and on this basis conclusions have not been drawn from the data.

Overall, the section 47A reforms appear to have had a positive impact for individuals receiving medication without any reported increase in adverse events. A number of submissions state that there have been:

- benefits for continuity of care,
- benefits for care delivery,
- best use of available skills, and
- creating opportunities for extended care assistants.

There are no major recommendations arising from the review, but there are a number of matters that require attention or further consideration. Those matters are:

- The wording in the guidelines should be reviewed to ensure that it is broad enough to cover updates and name changes to relevant units in the Health Training Packages.

- The guidelines developed for initial implementation should be revised and updated, and that the revisions should consider opportunities to remove duplication with other requirements.
- The availability of any increased range of Schedule 8 drugs in the disability sector should be the subject of further consideration by the relevant regulators, the sector peak body and health professional and employee organisations.
- ACST and the Pharmacy Guild should jointly review the issues raised by the Guild with a view to improving the arrangements that are in place between institutions and pharmacies.
- CYS should review the coverage of medication administration training provided to foster carers, with a view to ensuring that all carers have received appropriate training and have access to necessary information.
- The HACSU concern about consistency of training and practice is real, albeit difficult to address given the range of organisations that exist across the aged care and disability sectors. However it is suggested that any future revision of the DHHS guidelines is mindful of achieving consistency of training and practice across the sectors where this is possible.
- CYS should seek further advice on the issue of kinship carers and make changes to the guidelines and practice as appropriate.

## Terminology

Administration	the act of administering medication ie providing a dose of medication for a patient/another person to take
Assisted administration	Helping someone to take/use their medication
Medication	A scheduled substance (a medication currently listed on the "Poisons List" referred to in the <i>Poisons Act 1971</i> )
Organisation	A facility where medication is administered to persons who are residing together or have come together for a particular purpose, eg group homes, hostels, schools, day care etc
Scheduled substance	A substance specified in the Poisons List schedules
Schedule 2	Medication only available from a pharmacy (medicinal substances)
Schedule 3	Medication that can only be supplied by a pharmacist after consideration of the patient's symptoms (potent substances)
Schedule 4	Medication that requires a prescription of a medical practitioner, dentist, optometrist or nurse practitioner (restricted substances)
Schedule 8	Medication that requires a prescription of a medical practitioner or dentist and special controls around storage and recording due to the potential for misuse/abuse (narcotic substances)
Supply	As defined in the Act, supply includes to: <ol style="list-style-type: none"><li>Administer a substance, whether orally or subcutaneously, or by other means</li><li>Dispense a substance on prescription</li><li>Offer or agree to supply a substance</li></ol>

## Acronyms

ACST	Aged & Community Services Tasmania
ADD/ADHD	Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
ANF	Australian Nursing Federation
AMA	Australian Medical Association
CALD	Culturally and Linguistically Diverse
CYS	Children and Youth Services
DHHS	Department of Health and Human Services
ECA	Extended Care Assistant
EN	Enrolled Nurse
HACSU	Health and Community Services Union
NDST	National Disability Services Tasmania
RN	Registered Nurse

## Attachments

Attachment 1: Terms of Reference

Attachment 2: List of questions from Consultation Paper

Attachment 3: List of submissions received and consultation discussions

Attachment 4: Background to changes to enable carers to administer medications

Attachment 5: Extracts from *Poisons Act 1971* and *Poisons Regulations 2008*

Attachment 6: Medication administration by specific groups of carers

Attachment 7: Requirements for administration of particular substances

Attachment 8: Authorisation framework

### Terms of Reference

Department of Health and Human Services



#### Review of section 47A of the Poisons Act 1971

#### Terms of Reference

#### Background

- Section 47A of the *Poisons Act 1971* was inserted by the *Poisons Amendment Bill (No 2) 2009*, allowing regulations to be made to facilitate the administration and/or assistance in administration of legally supplied medication to persons by their carers.
- Section 47A provides that, despite the restrictions on the sale and supply of medicinal poisons, potent substances, restricted substances and narcotic substances (known as schedule 2, schedule 3, schedule 4 and schedule 8 substances respectively) in sections 26 and 47 of the Act, the *Poisons Regulations 2008* may enable some persons in some circumstances to administer certain substances in prescribed conditions.
- The intention of section 47A was to provide a clear legislative statement permitting the administration of legally supplied medication by carers to persons unable to undertake this administration on their own, in various settings. The medication must have been prescribed, dispensed and/or supplied by appropriately qualified health professionals in accordance with the Poisons Act and Regulations.
- Under section 47A eight new regulations were made (95A–95G)
  - Administration of certain substances by school staff (regulation 95A)
  - Administration of certain substances by Academy staff (regulation 95B)
  - Administration of certain substances by Polytechnic employees (regulation 95C)
  - Administration of certain substances by child carers (regulation 95D)
  - Administration of certain substances by foster-parents (regulation 95E)
  - Administration of certain substances by aged-care workers in residential care services (regulation 95EA)
  - Administration of certain substances by aged-care workers in community care services (regulation 95F)
  - Administration of certain substances by carers (regulation 95G)
  - Regulation 95 pertaining to disability service workers was already covered by the Regulations.

- Section 47B of the Act provides for an independent review of the regulations made under section 47A, to commence not less than two but not more than three years after commencement of section 47A. Section 47A commenced on 12 November 2009. The review would need to commence no later than November 2012.

### **Objectives**

The aim of the review is to ensure that the regulatory reforms under s.47 of the *Poisons Act 1971*:

- that allow the assistance with and/or administration to persons of their legally supplied scheduled substances by persons who are responsible or assist in their care have not resulted in adverse health outcomes; and
- ensure that enabling persons to assist others in the medication management of legally supplied scheduled substances has facilitated continuity in care and medication management.

### **Scope**

The scope of the review is to:

- (a) ensure the required guidelines as specified by the regulations are in place;
- (b) note any concerns or issues arising from the administration of those guidelines;
- (c) seek information on reported incidents and possible adverse outcomes that have resulted from carers assisting in or administering medication to a person in their care; and
- (d) look at observed impacts of regulatory reform.

### List of questions from consultation paper

The following questions have been designed to embrace the issues covered by the regulations generally and to include the experience of people receiving, administering or prescribing medications.

You may wish to address any or all of the following questions in your submission. Please feel free to provide the reasons for your response.

1. Has the authority given to carers to administer medications facilitated continuity of care and medication management and led to effective care of the person receiving the medication, for example by greater attendance at school, attending outings, improved quality of life?
2. Have the guidelines, protocols and required information been established in the required areas of care and are they adequate? If not, why?
3. Has it been possible to easily access the guidelines and how have they been made available?
4. Is the current variation between the guidelines appropriate, given the differing content of the respective regulations and carer roles?
5. What orientation procedure and training was put in place for existing carers and their supervisors and managers in relation to the practices enabled by the regulations and guidelines?
6. What orientation procedure and training are in place for new carers, supervisors and managers in relation to the practices enabled by the regulations and guidelines?
7. What additional training has been undertaken by the carers administering medication and how are any new skills and competencies maintained?
8. What supervision procedures have been established in relation to the administration of medication by carers?
9. Have any adverse health care events arisen because a carer has made an error in administering medication? Please provide de-identified details.
10. What protocols exist for the review of adverse health care events arising from a carer's error in medication administration, with a view to practice change or further education and training?
11. What protocols exist for the recording and reporting of medication administration errors?
12. Have staffing qualifications or requirements been changed in response to the ability for carers to administer medication and if so how?

13. Has the ability of an increased range of staff being able to administer medications, enabled health professionals to spend more time with clients and their care and/or to focus on more specialised areas of care?
14. Has the staff skill mix in organisations changed in a way that is attributable to carers being able to administer medication and if so, how has the skill mix changed?
15. Has the ability of carers to administer medication enabled the provision of timely health care in a way which would otherwise not have been available before the reforms?
16. Have health practitioners who are able to prescribe medication to people in their care, observed or been informed of any issues associated with the administration of medication by carers?
17. Have parents, relatives or friends of people in care observed or been informed of any issues associated with the administration of medication by carers?
18. If you are a person in care, have you encountered any difficulty or do you have any concerns with the administration of medication by your carers?
19. If you are a person in care, do you consider that there has been a benefit to the timeliness and/or quality of your ongoing health care, as a result of carers being able to administer some or all of your medications?

Are there any other issues that the review should consider? Please advise.

### List of submissions received and consultation discussions

#### Submissions

Aged & Community Services Tasmania including – Glenview Community Care Services Inc  
Australian Nursing Federation (Tasmanian Branch)  
Baptcare Karingal Community  
Department of Education  
Department of Health and Human Services – Children and Youth Services  
Health and Community Services Union  
National Disability Services Tasmania  
Pharmacy Guild of Australia (Tasmanian Branch)  
Southern Cross Care (Tasmania) Inc

#### Stakeholder discussions

Aged & Community Services Tasmania  
Australian Medical Association  
Pharmacy Guild of Australia (Tasmanian Branch)  
Tasmanian Foster Carers Association

### Background to changes to enable carers to administer medications

Before 2009, the *Poisons Act 1971* allowed some classes of persons to administer medications, for example parents and guardians in certain circumstances, and registered nurses, in accordance with the directions of a medical practitioner or in the case of Schedule 2 or 3 substances, in the course of nursing practice.

The proposed changes to establish a comprehensive approach to medication administration by carers were subject to consultation and significant debate in the 12 months before they were passed.

Key steps in the development of the amendments to the Act to enable carers to administer medications included:

- An initial discussion paper on the proposed changes released by the DHHS
- Consultation on a draft *Poisons Amendment Bill 2008* which included the changes relating to carer administration of medications
- Direct engagement with key stakeholders about the draft Bill
- Release of a further discussion paper on the proposed amendments for medication administration by carers (section 47A)
- Consultation on a draft *Poisons Amendment Bill (No. 2) 2009* and *Poisons Amendment Regulations 2009*, which responded to feedback on the section 47A discussion paper
- Revised draft *Poisons Amendment Regulations 2009* responding to further consultation
- A commitment during the second reading of the Bill that the Department would make available expert assistance and advice to aged-care providers in the implementation of the regulations

Subsequent developments include:

- The revised *Poisons Amendment Act (No. 2) 2009* commenced on 12 November 2009
- It was agreed during the 2009 consultation processes, that further work would be undertaken on administration of certain substances by aged-care workers in residential aged care facilities. Government agreed that guidelines and an implementation plan would be developed by the Department in consultation with stakeholders to facilitate consistency in implementation:
  - A key stakeholder reference group convened in January 2010, including representatives from the aged care sector, pharmacy associations and unions and contributed to the development of the guidelines
  - Three drafts of the guidelines were released for comment between March and May 2010
  - The final version of the Guidelines was sent to the Parliamentary Standing Committee on Subordinate Legislation in July 2010
  - The *Poisons Amendment Regulations 2010* (r. 95EA) was made by the Executive Council on 26 July 2010 and commenced on 1 September 2010.

### Extracts from *Poisons Act 1971*

#### **47A. Administration of medicinal poisons and potent, restricted and narcotic substances**

(1) This section applies to the following:

- (a) medicinal poisons;
- (b) potent substances;
- (c) restricted substances;
- (d) narcotic substances.

(2) Notwithstanding [section 26\(1\)](#) and [\(1B\)](#) and [section 47](#), the regulations may –

- (a) allow for any poisons or substances to which this section applies to be administered by such persons in such circumstances as the regulations prescribe; and
- (b) prescribe conditions and restrictions in respect of such administration.

(3) In this section "administer" includes making available for self-administration.

#### **47B. Review of regulations**

The Minister is to ensure that an independent review of regulations made under [section 47A](#) is undertaken and is commenced not earlier than 2 years after, but not later than 3 years after, the commencement of this section.

## Extracts from Poisons Regulations 2008

### 95. Administration of certain substances by disability service workers

(1) In this regulation –

**specified narcotic substance** means –

(a) dexamphetamine; or

(b) methylphenidate.

(2) A person may administer, or make available for self-administration, to another person a medicinal poison, potent substance, restricted substance or specified narcotic substance if –

(a) the person administering or making available the poison or substance is –

(i) employed by a disability services program approved by the Secretary or employed by a disability service provider who is funded by, and is the subject of a funding agreement with, the Department; and

(ii) acting in accordance with guidelines approved by the Secretary; and

(b) the person to whom the poison or substance is administered or made available –

(i) is receiving services from a disability services program approved by the Secretary or from a disability service provider who is funded by, and is the subject of a funding agreement with, the Department; and

(ii) is incapable of safely administering the poison or substance to himself or herself or needs assistance with self-administration; and

(c) in the case of a medicinal poison, the poison has been lawfully supplied and the administration is in accordance with the manufacturer's instructions; and

(d) in the case of a potent substance, the substance has been lawfully supplied and the administration is in accordance with the instructions of a medical practitioner, dentist, pharmaceutical chemist, eligible midwife, authorised nurse practitioner or optometrist; and

(e) in the case of a restricted substance, the substance has been lawfully prescribed and supplied for the person to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist, authorised optometrist, eligible midwife or authorised nurse practitioner; and

(f) in the case of a specified narcotic substance, the substance has been lawfully prescribed and supplied for the person to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner; and

(g) in the case of a specified narcotic substance, the storage and recording of the substance is in accordance with the guidelines referred to in [paragraph \(a\)\(ii\)](#).

## 95A. Administration of certain substances by school staff

(1) In this section –

**governing body** has the same meaning as in the [Education Act 1994](#);

**parent** has the same meaning as in the [Education Act 1994](#);

**principal** has the same meaning as in the [Education Act 1994](#);

**registered school** has the same meaning as in the [Education Act 1994](#);

**school** has the same meaning as in the [Education Act 1994](#);

**school ancillary staff** has the same meaning as in the [Education Act 1994](#);

**school staff** includes teachers, guidance officers, social workers, speech pathologists and school ancillary staff;

**school student** has the same meaning as in the [Education Act 1994](#);

**State school** has the same meaning as in the [Education Act 1994](#).

(2) A person may administer, or make available for self-administration, to a school student a medicinal poison, potent substance, restricted substance or narcotic substance if –

(a) the person administering or making available the poison or substance –

(i) is a member of the school staff; and

(ii) is acting –

(A) with the authority of the principal; and

(B) in the case of a State school, in accordance with guidelines approved by the Secretary of the department responsible for the administration of the [Education Act 1994](#); and

(C) in the case of a registered school, in accordance with guidelines approved by the governing body of the registered school; and

(b) the school student is incapable of safely administering the poison or substance to himself or herself or needs assistance with self-administration; and

(c) in the case of a medicinal poison, the poison has been lawfully supplied and the administration is in accordance with the manufacturer's instructions; and

(d) in the case of a potent substance, the substance has been lawfully supplied and the administration is in accordance with the instructions of a medical practitioner, dentist, pharmaceutical chemist, authorised nurse practitioner or optometrist; and

(e) in the case of a restricted substance, the substance has been lawfully prescribed and supplied for the school student to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist, authorised optometrist or authorised nurse practitioner; and

(f) in the case of a narcotic substance, the substance has been lawfully prescribed and supplied for the school student to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist or authorised nurse practitioner; and

(g) in the case of a narcotic substance, the storage and recording of the substance is in accordance with the guidelines referred to in [paragraph \(a\)\(ii\)\(B\)](#) or [\(C\)](#).

**(3)** The guidelines referred to in [subregulation \(2\)\(a\)\(ii\)\(B\)](#) and [\(C\)](#) must include the following:

**(a)** the form or method of authorisation that is to be given by a parent, medical practitioner, dentist, authorised optometrist, optometrist or authorised nurse practitioner;

**(b)** storage and recording requirements for a medicinal poison, potent substance, restricted substance or narcotic substance;

**(c)** protocols for the administration orally, subcutaneously or by any other means of a medicinal poison, potent substance, restricted substance or narcotic substance;

**(d)** protocols for dealing with narcotics specified in [Schedule 8](#) to the Poisons List;

**(e)** information on the appropriate disposal of an unused medicinal poison, potent substance, restricted substance or narcotic substance.

## 95B. Administration of certain substances by Academy staff

(1) In this section –

**Academy staff** includes teachers, guidance officers, social workers, speech pathologists and Academy support staff;

**Academy support staff** means a member of the Academy staff who is not –

- (a) a teacher; or
- (b) a guidance officer; or
- (c) a social worker; or
- (d) a speech pathologist;

**chief executive officer** has the same meaning as in the [Education and Training \(Tasmanian Academy\) Act 2008](#);

**parent** includes a guardian or other person having the care or control of an Academy student;

**post-Year 10 education** has the same meaning as in the [Education and Training \(Tasmanian Academy\) Act 2008](#).

(2) A person may administer, or make available for self-administration, to an Academy student a medicinal poison, potent substance, restricted substance or narcotic substance if –

(a) the person administering or making available the poison or substance –

(i) is a member of the Academy staff; and

(ii) is acting –

(A) with the authority of the principal; and

(B) in accordance with guidelines approved by the chief executive officer of the Academy; and

(b) the Academy student is incapable of safely administering the poison or substance to himself or herself or needs assistance with self-administration; and

(c) in the case of a medicinal poison, the poison has been lawfully supplied and the administration is in accordance with the manufacturer's instructions; and

(d) in the case of a potent substance, the substance has been lawfully supplied and the administration is in accordance with the instructions of a medical practitioner, dentist, pharmaceutical chemist, authorised nurse practitioner or optometrist; and

(e) in the case of a restricted substance, the substance has been lawfully prescribed and supplied for the Academy student to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist, authorised optometrist or authorised nurse practitioner; and

(f) in the case of a narcotic substance, the substance has been lawfully prescribed and supplied for the Academy student to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist or authorised nurse practitioner; and

**(g)** in the case of a narcotic substance, the storage and recording of the substance is in accordance with the guidelines referred to in [paragraph \(a\)\(ii\)\(B\)](#).

**(3)** The guidelines referred to in [subregulation \(2\)\(a\)\(ii\)\(B\)](#) must include the following:

**(a)** the form or method of authorisation that is to be given by a parent, medical practitioner, dentist, authorised optometrist, optometrist or authorised nurse practitioner;

**(b)** storage and recording requirements for a medicinal poison, potent substance, restricted substance or narcotic substance;

**(c)** protocols for the administration orally, subcutaneously or by any other means of a medicinal poison, potent substance, restricted substance or narcotic substance;

**(d)** protocols for dealing with narcotics specified in [Schedule 8](#) to the Poisons List;

**(e)** information on the appropriate disposal of an unused medicinal poison, potent substance, restricted substance or narcotic substance.

## 95C. Administration of certain substances by Polytechnic employees

(1) In this section –

**chief executive officer** has the same meaning as in the [Education and Training \(Tasmanian Polytechnic\) Act 2008](#);

**parent** includes a guardian or other person having the care or control of a Polytechnic student;

**Polytechnic employee** means a person appointed or employed for the purposes of the Polytechnic;

**post-Year 10 education and training** has the same meaning as in the [Education and Training \(Tasmanian Polytechnic\) Act 2008](#).

(2) A person may administer, or make available for self-administration, to a Polytechnic student a medicinal poison, potent substance, restricted substance or narcotic substance if –

(a) the person administering or making available the poison or substance –

(i) is a Polytechnic employee; and

(ii) is acting –

(A) with the authority of the principal; and

(B) in accordance with guidelines approved by the chief executive officer of the Polytechnic; and

(b) the Polytechnic student is incapable of safely administering the poison or substance to himself or herself or needs assistance with self-administration; and

(c) in the case of a medicinal poison, the poison has been lawfully supplied and the administration is in accordance with the manufacturer's instructions; and

(d) in the case of a potent substance, the substance has been lawfully supplied and the administration is in accordance with the instructions of a medical practitioner, dentist, pharmaceutical chemist, authorised nurse practitioner or optometrist; and

(e) in the case of a restricted substance, the substance has been lawfully prescribed and supplied for the Polytechnic student to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist, authorised optometrist or authorised nurse practitioner; and

(f) in the case of a narcotic substance, the substance has been lawfully prescribed and supplied for the Polytechnic student to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist or authorised nurse practitioner; and

(g) in the case of a narcotic substance, the storage and recording of the substance is in accordance with the guidelines referred to in [paragraph \(a\)\(ii\)\(B\)](#).

(3) The guidelines referred to in [subregulation \(2\)\(a\)\(ii\)\(B\)](#) must include the following:

(a) the form or method of authorisation that is to be given by a parent, medical practitioner, dentist, authorised optometrist, optometrist or authorised nurse practitioner;

(b) storage and recording requirements for a medicinal poison, potent substance, restricted substance or narcotic substance;

**(c)** protocols for the administration orally, subcutaneously or by any other means of a medicinal poison, potent substance, restricted substance or narcotic substance;

**(d)** protocols for dealing with narcotics specified in [Schedule 8](#) to the Poisons List;

**(e)** information on the appropriate disposal of an unused medicinal poison, potent substance, restricted substance or narcotic substance.

## 95D. Administration of certain substances by child carers, &c.

(1) In this regulation –

**approved provider** has the same meaning as in the Education and Care Services National Law (Tasmania);

**child** means a child who has not attained the age of 13 years and who is being provided with child care;

**child care** has the same meaning as in the [Child Care Act 2001](#);

**child carer** has the same meaning as in the [Child Care Act 2001](#);

**child care service** has the same meaning as in the [Child Care Act 2001](#);

**education and care service** has the same meaning as in the Education and Care Services National Law (Tasmania);

**guidelines** means guidelines issued under [subregulation \(6\)](#);

**nominated supervisor** has the same meaning as in the Education and Care Services National Law (Tasmania);

**parent** includes a guardian or other person having the care or control of a child;

**person-in-charge** has the same meaning as in the [Child Care Act 2001](#);

**Regulatory Authority** has the same meaning as in the Education and Care Services National Law (Tasmania).

(2) A person may administer, or make available for self-administration, to a child attending child care a medicinal poison, potent substance, restricted substance or narcotic substance if –

(a) the person administering or making available the poison or substance –

(i) is a child carer; and

(ii) is acting with the authority of the person-in-charge given either specifically to the child carer or by the application of the general written policies of the child care service; and

(iii) is acting in accordance with Child Care Standards approved by the Secretary of the department responsible for the administration of the [Child Care Act 2001](#); and

(b) the child is incapable of safely administering the poison or substance to himself or herself or needs assistance with self-administration; and

(c) in the case of a medicinal poison, the poison has been lawfully supplied and the administration is in accordance with the manufacturer's instructions; and

(d) in the case of a potent substance, the substance has been lawfully supplied and the administration is in accordance with the instructions of a medical practitioner, dentist, pharmaceutical chemist, authorised nurse practitioner or optometrist; and

(e) in the case of a restricted substance, the substance has been lawfully prescribed and supplied for the child to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist, authorised optometrist or authorised nurse practitioner; and

(f) in the case of a narcotic substance, the substance has been lawfully prescribed and supplied for the child to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist or authorised nurse practitioner; and

**(g)** in the case of a narcotic substance, the storage and recording of the substance is in accordance with the Child Care Standards referred to in [paragraph \(a\)\(ii\)\(B\)](#).

**(3)** The Child Care Standards referred to in [subregulation \(2\)\(a\)\(ii\)\(B\)](#) must include the following:

- (a)** the form or method of authorisation that is to be given by a parent, medical practitioner, dentist, authorised optometrist, optometrist or authorised nurse practitioner;
- (b)** storage and recording requirements for a medicinal poison, potent substance, restricted substance or narcotic substance;
- (c)** protocols for the administration orally, subcutaneously or by any other means of a medicinal poison, potent substance, restricted substance or narcotic substance;
- (d)** protocols for dealing with narcotics specified in [Schedule 8](#) to the Poisons List;
- (e)** information on the appropriate disposal of an unused medicinal poison, potent substance, restricted substance or narcotic substance.

**(4)** A person may administer, or make available for self-administration, to a child attending an education and care service a medicinal poison, potent substance, restricted substance or narcotic substance if –

**(a)** the person administering or making available the poison or substance –

**(i)** is an approved provider; and

**(ii)** is acting with the authority of the nominated supervisor given either specifically to the approved provider or by the application of the general written policies of the education and care service; and

**(iii)** is acting in accordance with the regulations made under the Education and Care Services National Law (Tasmania) and the guidelines; and

**(b)** the child is incapable of safely administering the poison or substance to himself or herself or needs assistance with self-administration; and

**(c)** in the case of a medicinal poison, the poison has been lawfully supplied and the administration is in accordance with the manufacturer's instructions; and

**(d)** in the case of a potent substance, the substance has been lawfully supplied and the administration is in accordance with the instructions of a medical practitioner, dentist, pharmaceutical chemist, authorised nurse practitioner or optometrist; and

**(e)** in the case of a restricted substance, the substance has been lawfully prescribed and supplied for the child to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist, authorised optometrist or authorised nurse practitioner; and

**(f)** in the case of a narcotic substance, the substance has been lawfully prescribed and supplied for the child to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist or authorised nurse practitioner; and

**(g)** in the case of a narcotic substance, the storage and recording of the substance is in accordance with the regulations made under the Education and Care Services National Law (Tasmania) and the guidelines.

**(5)** The requirements of [subregulation \(4\)](#) apply in relation to a child attending an education and care service in addition to any requirements relating to the administration, or the making available for administration, of medication specified in the Education and Care Services National Law (Tasmania).

**(6)** The Regulatory Authority may issue guidelines for the purposes of [subregulation \(4\)](#) that are not contrary to the regulations made under the Education and Care Services National Law (Tasmania).

**(7)** The Regulatory Authority must include in the guidelines the following, unless to do so would cause the guidelines to be contrary to the regulations made under the Education and Care Services National Law (Tasmania):

- (a)** the form or method of authorisation that is to be given by a parent, medical practitioner, dentist, authorised optometrist, optometrist or authorised nurse practitioner;
- (b)** storage and recording requirements for a medicinal poison, potent substance, restricted substance or narcotic substance;
- (c)** protocols for the administration orally, subcutaneously or by any other means of a medicinal poison, potent substance, restricted substance or narcotic substance;
- (d)** protocols for dealing with narcotic substances specified in [Schedule 8](#) to the Poisons List;
- (e)** information on the appropriate disposal of an unused medicinal poison, potent substance, restricted substance or narcotic substance.

### **95E. Administration of certain substances by foster-parents**

A person may administer, or make available for self-administration, to a child in his or her care a medicinal poison, potent substance, restricted substance or narcotic substance if –

**(a)** the person administering or making available the poison or substance –

**(i)** is a foster-parent; and

**(ii)** is acting in accordance with guidelines approved by the Secretary; and

**(b)** the child to whom the poison or substance is administered or made available –

**(i)** is under the guardianship or in the custody of the Secretary of the department responsible for the administration of the [Children, Young Persons and Their Families Act 1997](#); and

**(ii)** is incapable of safely administering the poison or substance to himself or herself or needs assistance with self-administration; and

**(c)** in the case of a medicinal poison, the poison has been lawfully supplied and the administration is in accordance with the manufacturer's instructions; and

**(d)** in the case of a potent substance, the substance has been lawfully supplied and the administration is in accordance with the instructions of a medical practitioner, dentist, pharmaceutical chemist, authorised nurse practitioner or optometrist; and

**(e)** in the case of a restricted substance, the substance has been lawfully prescribed and supplied for the child to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist, authorised optometrist or authorised nurse practitioner; and

**(f)** in the case of a narcotic substance, the substance has been lawfully prescribed and supplied for the child to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist or authorised nurse practitioner; and

**(g)** in the case of a narcotic substance, the storage and recording of the substance is in accordance with the guidelines referred to in [paragraph \(a\)\(ii\)](#).

## **95EA. Administration of certain substances by aged-care workers in residential care services**

(1) In this regulation –

**aged care service** has the same meaning as in the *Aged Care Act 1997* of the Commonwealth;

**residential care** has the same meaning as in the *Aged Care Act 1997* of the Commonwealth;

**residential care service** has the same meaning as in the *Aged Care Act 1997* of the Commonwealth;

**specified narcotic substance** means buprenorphine in patches for transdermal delivery.

(2) A person who is not a nurse may administer, or make available for self-administration, to another person who is being provided with residential care by a residential care service, a medicinal poison, potent substance, restricted substance or the specified narcotic substance if –

(a) the person administering or making available the poison or substance –

(i) is employed by an aged care service that provides a residential care service and is acting with the authority of the person in charge of that service; and

(ii) is acting under the general supervision or direction of a registered nurse; and

(iii) has met the requirements of relevant nationally accredited training modules relating to the administration and storage of medication and maintains any competency requirements of those modules; and

(iv) is acting in accordance with guidelines approved by the Secretary; and

(b) the other person is incapable of safely administering the poison or substance to himself or herself or needs assistance with self-administration; and

(c) in the case of a medicinal poison, the poison has been lawfully supplied and the administration is in accordance with the manufacturer's instructions; and

(d) in the case of a potent substance, the substance has been lawfully supplied and the administration is in accordance with the instructions of a medical practitioner, dentist, pharmaceutical chemist, authorised nurse practitioner or optometrist; and

(e) in the case of a restricted substance, the substance has been lawfully prescribed and supplied for the person to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist, authorised optometrist or authorised nurse practitioner; and

(f) in the case of the specified narcotic substance, the substance has been lawfully prescribed and supplied for the person to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist or authorised nurse practitioner.

## **95F. Administration of certain substances by aged-care workers in community care services**

(1) In this regulation –

**aged care service** has the same meaning as in the *Aged Care Act 1997* of the Commonwealth;

**community care** has the same meaning as in the *Aged Care Act 1997* of the Commonwealth;

**community care service** has the same meaning as in the *Aged Care Act 1997* of the Commonwealth.

(2) A person who is not a nurse may administer, or make available for self-administration, to another person, who is being provided with community care by a community care service, a medicinal poison, potent substance, restricted substance or narcotic substance if –

(a) the person administering or making available the poison or substance –

(i) is employed by an aged care service that provides a community care service and is acting with the authority of the person in charge of that service; and

(ii) is acting under the general supervision or direction of a registered nurse; and

(iii) has met the requirements of relevant nationally accredited training modules relating to the administration and storage of medication and maintains any competency requirements of those modules; and

(b) the other person is incapable of safely administering the poison or substance to himself or herself or needs assistance with self-administration; and

(c) in the case of a medicinal poison, the poison has been lawfully supplied and the administration is in accordance with the manufacturer's instructions; and

(d) in the case of a potent substance, the substance has been lawfully supplied and the administration is in accordance with the instructions of a medical practitioner, dentist, pharmaceutical chemist, authorised nurse practitioner or optometrist; and

(e) in the case of a restricted substance, the substance has been lawfully prescribed and supplied for the person to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist, authorised optometrist or authorised nurse practitioner; and

(f) in the case of a narcotic substance, the substance has been lawfully prescribed and supplied for the person to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist or authorised nurse practitioner.

## **95G. Administration of certain substances by carers**

(1) Subject to [subregulation \(2\)](#), a person may administer, or make available for self-administration, to another person a medicinal poison, potent substance, restricted substance or narcotic substance if –

- (a) the person administering the poison or substance, or making it available, has the care of, and responsibility for, the other person; and
- (b) the other person is incapable of safely administering the poison or substance to himself or herself or needs assistance with self-administration; and
- (c) in the case of a medicinal poison, the poison has been lawfully supplied and the administration is in accordance with the manufacturer's instructions; and
- (d) in the case of a potent substance, the substance has been lawfully supplied and the administration is in accordance with the instructions of a medical practitioner, dentist, pharmaceutical chemist, authorised nurse practitioner or optometrist; and
- (e) in the case of a restricted substance, the substance has been lawfully prescribed and supplied for the person to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist, authorised optometrist or authorised nurse practitioner; and
- (f) in the case of a narcotic substance, the substance has been lawfully prescribed and supplied for the person to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist or authorised nurse practitioner.

(2) This regulation does not authorise the administration, or making available, of a poison or substance by –

- (a) a person employed by a disability services program approved by the Secretary or employed by a disability service provider who is funded by, and is the subject of a funding agreement with, the Department; or
- (b) a member of school staff within the meaning of [regulation 95A](#); or
- (c) a member of Academy staff within the meaning of [regulation 95B](#); or
- (d) a Polytechnic employee within the meaning of [regulation 95C](#); or
- (e) a child carer within the meaning of [regulation 95D](#); or
- (f) a foster-parent within the meaning of [regulation 95E](#); or
- (fa) a person employed by an aged care service that provides a residential care service within the meaning of [regulation 95EA](#); or
- (g) a person employed by an aged care service that provides a community care service within the meaning of [regulation 95E](#); or
- (h) a person employed by a medical institution or day-treatment centre; or
- (i) a person employed at a detention centre.

### Medication administration by specific groups of carers

#### Medication administration by disability service workers (r. 95)

Regulation 95 allows disability service workers to administer, or make available for self-administration, certain medications regulated under the Act if:

- a. the worker is employed by a disability services program approved by the Secretary (of the Department of Health and Human Services) or employed by a disability service provider as described in the regulation
- b. the worker is acting in accordance with guidelines approved by the Secretary [Administration of Medication Guidelines](#)
- c. the person to whom the medication is administered or made available is receiving disability services as described in the regulation
- d. the person is incapable of safely administering the substance him or herself or needs assistance with self-administration
- e. the specific requirements relating to the substance specified in the regulations (see Attachment 4) are met.

Regulation 95 includes a definition of specified narcotic substance as dexamphetamine or methylphenidate. These are the only narcotic substances disability services workers can administer.

The Guidelines issued by the Secretary are quite detailed, and cover different categories of medication, different methods of administration, training, record keeping and other matters.

#### Medication administration in educational institutions (rs. 95A, 95B, 95C)

Three regulations provide for medication administration in educational institutions, by school staff (r. 95A), Academy staff (r. 95B) and Polytechnic staff (r. 95C). The framework for administration in all three cases is the same:

##### *School staff (r. 95A)*

Regulation 95A allows school staff to administer, or make available for self-administration, certain medications regulated under the Act if:

- a. the staff member is acting with the authority of the principal and in accordance with relevant guidelines approved by the Secretary of the Department of Education, which address the issues specified in the regulation (see section 3 above)
- b. the school student is incapable of safely administering the substance him or herself or needs assistance with self-administration
- c. the specific requirements relating to the substance specified in the regulations (see Attachment 4) are met.

##### *Academy staff (r. 95B)*

Regulation 95B allows Academy staff to administer, or make available for self-administration, certain medications regulated under the Act if:

- a. the staff member is acting with the authority of the principal and in accordance with relevant guidelines approved by the Chief Executive Officer of the Academy which address the issues set out in the regulations (see section 3 above)
- b. the Academy student is incapable of safely administering the substance him or herself or needs assistance with self-administration
- c. the specific requirements relating to the substance specified in the regulations (see Attachment 4) are met.

#### *Polytechnic employees (r. 95C)*

Regulation 95C allows Polytechnic employees to administer, or make available for self-administration, certain medications regulated under the Act if:

- a. the employee is acting with the authority of the principal and in accordance with relevant guidelines approved by the Chief Executive Officer of the Polytechnic which address the issues set out in the regulations (see section 3 above)
- b. the Polytechnic student is incapable of safely administering the substance him or herself or needs assistance with self-administration
- c. the specific requirements relating to the substance specified in the regulations (see Attachment 4) are met.

The Department of Education issued [Administration of Medication Procedures](#) in 2012. The procedures address the form of authorisation required by a parent or health practitioner, storage and recording requirements and protocols for administration of medication generally and for specific types of medication eg epipens and asthma medication. However, the procedures are fairly brief and do not appear to include specific protocols for dealing with different categories of substances such as narcotics.

#### **Medication administration by Child carers (r. 95D)**

Regulation 95D provides for medication administration by child carers and child care providers.

Regulation 95D allows child carers to administer, or make available for self-administration, certain medications regulated under the Act if:

- a. the child-carer is acting with the authority of the person-in-charge and in accordance with Child Care Standards approved by the Secretary of the Department of Education, which address the issues specified in the regulation (see below and section 3 above)
- b. the child is incapable of safely administering the substance him or herself or needs assistance with self-administration
- c. the specific requirements relating to the substance specified in the regulations (see Attachment 4) are met.

Similarly, Regulation 95D allows approved child carer providers to administer, or make available for self-administration, certain medications regulated under the Act if:

- a. the provider is acting with the authority of the nominated supervisor given either specifically to the approved provider or by the application of the general written policies of the education and care service and in accordance with Child Care

- Standards approved by the Secretary of the Department of Education, which address the issues specified in the regulation (see section 3 above)
- b. the child is incapable of safely administering the substance him or herself or needs assistance with self-administration
  - c. the specific requirements relating to the substance specified in the regulations (see Attachment 4) are met.

The Department of Education has developed [Centre Based Care Standards Class 4](#) and [Centre Based Care Standards Class 5](#) which refer to medication administration.

The Department of Education has also issued [Guidelines for administration of medication in Education and Care Services: \(Tasmanian Poisons Regulations 2008\)](#). These guidelines do not apply to schools.

### **Medication administration by Foster-parents (r. 95E)**

Regulation 95E allows foster-parents to administer, or make available for self-administration, certain medications regulated under the Act if the person:

- a. the foster-parent is acting in accordance with guidelines approved by the Secretary of the DHHS
- b. the child is under the guardianship or in the custody of the Secretary
- c. the child is incapable of safely administering the substance him or herself or needs assistance with self-administration
- d. the specific requirements relating to the substance specified in the regulations (see Attachment 4) are met.

The DHHS has developed [Medication Guidelines for Carers of Children in out of home care](#) which are part of the Child Protection Practice Manual. The guidelines deal with medication packaging and transportation, secure storage, medication register, administering different types of medication, assessment and monitoring of medication management and medication errors or adverse reactions..

### **Medication administration aged-care workers in residential care services (r. 95EA)**

Regulation 95EA does not cover nurses, who have separate powers under the Act. Regulation 95EA allows aged-care workers in residential care services to administer, or make available for self-administration to a person being provided with residential care by a residential care service, certain medications regulated under the Act if:

- a. the aged-care worker is acting with the authority of the person in charge of the residential care service, and
- b. the worker is acting under the general supervision or direction of a registered nurse, and
- c. the worker has undertaken the training specified in the regulation
- d. the worker is acting in accordance with relevant guidelines approved by the Secretary of the DHHS
- e. the person being provided with the aged-care residential service is incapable of safely administering the substance him or herself or needs assistance with self-administration

- f. with the specific requirements relating to the substance specified in the regulations (see Attachment 4) are met.

Regulation 95EA includes a definition of specified narcotic substance buprenorphine in patches for transdermal delivery. This is the only narcotic substance aged-care workers in residential care services can administer.

The DHHS Secretary has approved quite detailed guidelines for the [Administration of certain substances by aged-care workers in residential aged care services](#). The guidelines deal with different roles in medication administration, including the provider, aged-care worker, registered nurse and enrolled nurse. The guidelines specify education and competency requirements and cover particular types of medication and administration methods.

### **Medication administration aged-care workers in community care services (r. 95F)**

Regulation 95F does not cover nurses, who have separate powers under the Act. Regulation 95F allows aged-care workers in community care services to administer, or make available for self-administration to a person being provided with community care by a community care service, certain medications regulated under the Act if:

- a. the aged-care worker is acting with the authority of the person in charge of the community care service, and
- b. the worker is acting under the general supervision or direction of a registered nurse, and
- c. the worker has undertaken the training specified in the regulation, and
- d. the person being provided with the community care is incapable of safely administering the substance him or herself or needs assistance with self-administration
- e. the specific requirements relating to the substance specified in the regulations (see Attachment 4) are met.

Regulation 95F does not require compliance with particular guidelines.

### **Medication administration carers (r. 95G)**

Regulation 95G allows a person to administer, or make available for self-administration to another person, certain medications regulated under the Act if:

- a. the person has care of and responsibility for the other person
- b. the other person is incapable of safely administering the substance him or herself or needs assistance with self-administration
- c. the specific requirements relating to the substance specified in the regulations (see Attachment 4) are met.

The regulation does not apply to a number of specific categories of carers:

- disability service workers,
- the carers covered by regulations 95A – F,
- a person employed by a medical institution or day-treatment centre, or

- a person employed at a detention centre.

Regulation 95G does not require compliance with particular guidelines.

### Requirements for administration of particular substances

The *Poisons Regulations* apply the following general framework to medication administration by different groups of carers

<i>Requirement for medication</i>	<i>Description</i>	<i>Carer group</i>
<i>Inability to self-administer</i>	the person cared for is incapable of safely administering the poison or substance to him or herself or needs assistance with self-administration	
<i>Medicinal poisons</i>	in the case of a medicinal poison, the poison has been lawfully supplied and the administration is in accordance with the manufacturer's instructions	School staff (r. 95A) Academy staff (r. 95B)
<i>Potent substance</i>	in the case of a potent substance, the substance has been lawfully supplied and the administration is in accordance with the instructions of a medical practitioner, dentist, pharmaceutical chemist, authorised nurse practitioner or optometrist	Polytechnic employees (r. 95C) child carers (r. 95D(2)(b)) approved child care providers (r. 95D(4)(b))
<i>Restricted substance</i>	in the case of a restricted substance, the substance has been lawfully prescribed and supplied for the person to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist, authorised optometrist or authorised nurse practitioner	foster parents (r. 95E) residential aged-care workers (r. 95EA) community care aged care workers (r. 95F) carers (r. 95G)
<i>Narcotic substance</i>	in the case of a narcotic substance, the substance has been lawfully prescribed and supplied for the individual to whom it is being administered or made available and the administration is in accordance with the directions of a medical practitioner, dentist, or authorised nurse practitioner	
<i>Storage and recording of narcotic substances</i>	in the case of a narcotic substance, the storage and recording of the substance is in accordance with the relevant guidelines	School staff (r. 95A) Academy staff (r. 95B) Polytechnic employees (r. 95C) child carers (r. 95D(2)(b)) approved child care providers (r. 95D(4)(b)) foster parents (r. 95E)

### Authorisation framework

Administration by disability service workers	Employed by a disability service program approved by the Secretary or a disability service provider funded by the DHHS and acting in accordance with relevant guidelines specified in the regulation
Administration by school staff	The authority of the principal and in accordance with guidelines specified in the regulation
Administration by Academy staff	The authority of the principal and in accordance with guidelines specified in the regulation
Administration by Polytechnic staff	The authority of the principal and in accordance with guidelines specified in the regulation
Administration by child carers	The authority of the person-in-charge and in accordance with Child Care Standards specified in the regulation
Administration by approved child care providers	The authority of the nominated supervisor and in accordance with regulations made under the Education and Care Services National Law (Tasmania) and the guidelines
Administration by foster-parents	Acting in accordance with guidelines approved by the Secretary of the Department of Health and Human Services
Administration by aged-care workers in residential care services	<p>Person is employed by an aged-care service that provides a residential care service and is acting with the authority of the person in charge of that service, and</p> <p>Is acting under the general supervision or direction of a registered nurse, and</p> <p>Has met the requirements of relevant nationally accredited training modules relating to the administration and storage of medication and maintains any competency requirements of those modules, and</p> <p>Is acting in accordance with guidelines approved by the Secretary</p>
Administration by aged-care workers in community care services	<p>Person is employed by an aged-care service that provides a community care service and is acting with the authority of the person in charge of that service, and</p> <p>Is acting under the general supervision or direction of a registered nurse, and</p> <p>Has met the requirements of relevant nationally accredited training modules relating to the administration and storage of medication and maintains any competency requirements of those modules</p>
Administration by carers	Person has the care of and responsibility for the person to whom the medication is administered or made available