AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Case Study - Safe and Appropriate use of Psychotropic Medicines - Residential Aged Care

Evidence-based clinical care for older people

AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

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About this Case Study

This is one of a suite of resources to support aged care providers to deliver evidence-based care to older people.

It has the dual aim of helping aged care providers to understand their role in mitigating the risks of using psychotropic medicines to manage behaviour in older people with cognitive disability or impairment as described in the Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard (2024); and assisting aged care providers meet their obligations to provide quality, evidence-based clinical care, as described in the Aged Care Quality standards.

The Aged Care Quality standards require providers to deliver quality clinical care that is **person-centred**, **safe**, **coordinated**, and **evidence based**.

Providers can do this by:

- making sure older people are at the centre of their care
- making sure staff know their roles and accountabilities for delivery of clinical care
- implement processes and design care that is based on current evidence
- agreeing on roles and responsibilities for communication and care with health professionals and services, internal and external to the provider
- working towards a digital system for clinical information that can communicate across IT platforms
- making sure sufficiently trained and qualified staff, deliver care that meets the needs of older people using the service
- making sure the staff work within their scope of practice, and they have supervision to enable them to effectively perform their roles
- implementing a medication management system that aligns with the Guiding principles for medication management in residential aged care facilities and relevant state and territory legislation as relevant to the service category.

For more information about the Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard and its application in aged care settings see the fact sheet Safe and Appropriate use of Psychotropic Medicines - Aged Care.

In this case study, "provider staff" includes all staff and health professionals employed or contracted by the provider. "Other health professionals" include the range of health professionals, including medical specialist and allied health professionals, who contribute to multidisciplinary care but are not directly employed by the provider. Where there are specific roles relevant to the case study, these are explicitly mentioned.

How to use this case study

The fictional scenarios outlined follow the path of an older person with residential care provider rather than the numerical order of the Quality statements of the Clinical Care Standard. The focus is on the systems and processes that should be in place to support care delivery in a residential aged care home.

1. **Person-centred care - commencement with the provider, identifying their care needs and the roles and responsibilities for delivery of care**
2. **Medication management**
3. **Managing changed behaviours**
4. **Transitions of Care - acute deterioration resulting in hospital admission and discharge**

Where there is a link to the Clinical Care Standard – Open this to view evidence-based practice for health professionals.

KEY	
The context 	A fictional scenario based around Mr Ronit Sharma, a 72-year-old, retired engineer who was diagnosed with Parkinson's disease at 67 years old. He received aged care services from a fictitious residential care provider, Sunshine Care, in rural Queensland. Mr Sharma was born in India and migrated to Australia in his late 40's. His wife passed away several years prior to this scenario and his entry into residential aged care.
The aged care service	Describes how the provider delivered care that aligns with the Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard (CCS) and the Aged Care Quality (ACQ) Standards
Applying the standards	**In this case study** Evidence-based practice examples Alignment with standards and key concepts
Strategies for improvement	Where care could be improved in this scenario
Discussion Questions	Discussion questions are included to prompt consideration of concepts in this case study as appropriate to the following roles within the organisation **care workers or other non-clinical staff** **clinical care staff and care coordinators or service managers** **the governing body**

KEY	
	Evidence-based practice care of older people with cognitive impairment or disability as outlined in the quality statements in the **CCS**
	Related *Outcomes* (requirements) and the *Actions* that describe evidence-based practice care of older people with cognitive disability or impairment in the Aged Care Quality Standards **The graphic represeting the Aged Care Quality standards is owned by the Aged Care Quality and Safety Commission. For use of material that includes this logo please contact the Aged Care Quality and Safety Commission.*

Translating the Psychotropic Medicines in Cognitive Disability and Impairment - Clinical Care Standard for residential aged care providers

	Person-centred Care
The Context 	**Commencement of Care with Sunshine Care** Mr Sharma, a retired engineer, was diagnosed with Parkinson's disease and has moderate cognitive impairment. His symptoms included tremors, rigidity, and bradykinesia (slowness of movement). His daughter worked full time and was concerned that Mr Sharma was not coping at home and that he was exhibiting some unusual behaviours. She had found him confused and extremely upset several times when visiting and he had told her that people were stealing his clothes. He also appeared to be able to see people in the room that were not there and would shout aggressively at them and sometime people he was with. Mr Sharma had a regular GP who he preferred to see. He was reviewed by a geriatrician for diagnosis and treatment of Parkinson's several years prior to his admission to Sunshine Care. He also had several virtual care appointments for review of his Parkinson's disease symptoms with a neurologist. He previously accessed six sessions with a physiotherapist to build strength to reduce the risk of falls at home and had a review with a mental health counsellor. The Aged Care Assessment Team (ACAT) used the integrated assessment tool (IAT) to determine his eligibility for aged care and identify his needs. Mr Sharma was born in India and while he was a fluent English speaker he had a strong accent, and he had started to occasionally use Hindi words in conversation.
The Aged Care Service	On commencement of care with Sunshine Care, the Registered Nurse (RN) and care coordinator conducted a comprehensive assessment, informed by the previously conducted ACAT assessment, which included cognitive assessments, physical assessments and assessments of his abilities to participate in activities of daily living. Mr Sharma's current medicines were documented in the providers medication management system and were reviewed by the community pharmacist. Mr Sharma and his daughter, at his request, were both included in care planning and Mr Sharma's preferences for communication were identified. The care coordinator also worked with Mr Sharma to register him with his general practice for My Medicare. The practice then registered Mr Sharma for regular visits and care planning through the General Practice in Aged Care Incentive (GPACI). Mr Sharma's practice conducted a comprehensive medical assessment to inform his care planning. Mr Sharma's care plan included: • preferred routines for eating, sleeping and showering

	Person-centred Care
	• communication needs • his preferred meals • social activities he enjoyed • established connections in the community he wanted to maintain • individualised plan for supporting changing behaviour or behaviours of concern • his medicines chart and up to date medicines list that was reviewed by a community pharmacist • contact details and information about care he received from other health professionals such as the neurologist and physiotherapist • a plan for assessment and reassessment regularly and if there were changes The care plan was available to care staff in the providers digital care management system and was regularly reviewed to make sure it was fit for purpose. Mr Sharma agreed that his daughter should be his support person and wanted her to be involved in planning his care. He has nominated her as his substitute decision maker, through an Advance Care Directive, should he lose capacity.
 	Quality statement 1 - Person-centred care A person receives health care that is driven by their individual preferences, needs and values, and that upholds their personal dignity, human rights and legal rights. The person is supported to be active participants in making informed choices about their care, together with their family, support people or nominated decision-maker as appropriate. Aged Care Quality Standards **Standard 1:** Outcome 1.1 (all) Outcome 1.2 (all) Outcome 1.3 (all) **Standard 2:** Outcome 2.1 (all) Outcome 2.2 (action 2.2.2) Outcome 2.9 (action 2.9.6) **Standard 3:** Outcome 3.1 (3.1.1, 3.1.2, 3.1.3, 3.1.4) Outcome 3.2 (3.2.1, 3.2.2, 3.2.6) Outcome 3.3 (3.3.1, 3.3.2) Outcome 3.4 (all) **Standard 5**: Outcome 5.3 (action 5.3.1) 5.4 (action 5.4.1) 5.6 (action 5.6.2) **Standard 7**: Outcome 7.1 (7.1.1, 7.1.2, 7.1.3)

	Person-centred Care
Applying the standards	**In this case study** Sunshine care agreed on and documented the care they would deliver, and the care he received from external health professionals such as regular physiotherapy and regular reviews with a GP and his neurologist. Mr Sharma was supported to access a comprehensive medical assessment with his GP. Mr Sharma, supported by his daughter, participated in decisions about the care he would receive. Care plans have a regular review schedule Delivering care that is person-centred means that each older person has care that considers their individual needs, goals for care and preferences. This is a key concept in both the CCS and the ACQ standards. It supports the person to be considered holistically and that contextual factors, such as whether the person has a cognitive impairment, are considered in care planning and communication strategies. **Comprehensive assessment supports care that is planned to meet an older person's individual needs and is in line with their goals and preferences.** **Cultural safety and equity** Person-centred care approaches for people from CALD backgrounds should emphasise the role of cultural belonging and acknowledge potential cultural differences in beliefs about treatments, care and decision-making.
Strategies for improvement	**In this situation** making sure that assessment tools were validated and appropriate for use for older people with cognitive impairment or from diverse backgrounds would be important. Identifying if Mr Sharma had a My Health Record (MHR) and asking his consent to access the information in MHR could make getting to know his medical history easier and faster. For Mr Sharma to experience more person-centred care, provider staff could also support him by knowing the impact his cognitive impairment may have on his ability to communicate and make decisions about his care.

	Person-centred Care
	Cultural safety and equity Consider the varying meanings of the term 'family' in different cultures. For example, family may include people who are not first- or second-degree relatives but culturally have a close tie to the person or are important in their culture and link to country.
Discussion questions	**Care Worker** How do you make sure you understand an older person's preferences for care? What do you do or ask to make sure those preferences are current? **Clinical/ Care co-ordinator/ service manager** What are the processes in place for when an older person does not have a regular GP or support from family? How are local community engagement opportunities identified to ensure cultural and spiritual connections can be maintained after entry into residential aged care? What are the processes to agree on and document roles and responsibilities for care between the provider, other health professionals and family? **The Governing Body** How is the satisfaction of an older person with the culture and care in the service understood and prioritised by the governing body?

	Medication management
The Context 	**This case has intentionally used a scenario where the use of a PRN antipsychotic may be inappropriate to explore the role of aged care providers in identifying and responding to this risk.** Prior to his entry to Sunshine Care, Mr. Sharma was prescribed a low dose of "as required" (PRN) quetiapine (an atypical antipsychotic) to manage his delusions and severe distress. While the quetiapine appeared to help to reduce acute agitation and delusions, it also made him drowsy and disoriented at times. Mr Sharma was also taking Amlodipine, 5 mg daily for hypertension, and Vitamin D, 1000 IU daily for bone health. There were written instructions for the quetiapine including that it was **only to be used when non-medication strategies were ineffective** and a behaviour support plan that described non-medication strategies that helped Mr Sharma. CCS - Appropriate reasons for prescribing psychotropic medicines Mr Sharma's GP provided written instructions for the use of quetiapine that included what observations needed to be documented and reported back to the prescriber, but there was sparse detail about exactly when it could or should be used. CCS - Informed consent for psychotropic medicines
The Aged Care Service	Sunshine Care had processes in place for the management, documentation and administration of medicines, including when they were prescribed PRN, in-line with the Guiding principles for Medication Management. Mr Sharma's medicines were reviewed by a credentialed pharmacist (RMMR). The provider noted that, in this case, use is considered a restrictive practice (chemical restraint). The RN was responsible for the administration and documentation of medicines in the providers system. Sunshine care's clinical information systems included an electronic National Residential Medication Chart (eNRMC) and a medicines list that was updated regularly. Mr Sharma's consent for and understanding of the medicines he was taking, and their side effects was reviewed on commencement of care and also discussed with his daughter. Provider staff that had training in medicines administration understood which medicines Mr Sharama took, the risks and benefits of using them and what they needed to monitor and observe about their effects.

	Medication management
Applying the standards	**In this case study** provider staff that administer Mr Sharma's medicines are trained and understand the risks associated with use of psychotropic medicines and where **use is inappropriate** or **considered a restrictive practice.** Provider staff understood the processes for escalation and their role in identifying risk. Mr Sharma was reviewed by his GP and a RMMR was conducted by a credentialed pharmacist. While prescribing medicines is not always the responsibility of aged care provider staff, supporting safe use of medicines is. Trained, qualified, supervised and skilled provider staff understand the risks involved with use of psychotropic medicines, what is appropriate use and what is considered a restrictive practice as defined in legislation. Providers also have responsibilities to ensure older people have the information they need to make decisions about their care, including for medicines they are prescribed and if a restrictive practice is used. Informed consent, in this case is given to the prescriber, however a provider that administers medicines should ensure **consent is documented** in their system and that there is a process to withdrawn consent. Understanding these concepts and demonstrating that a provider has processes in place to safely manage medicines, in line with Guiding principles for medication management in residential aged care facilities collection, meets the requirements of the **ACQ standards** and the intent of the **CCS**..
Strategies for improvement	**In this situation** the detail provided by the prescriber was not sufficient**.** It is necessary to have processes to communicate with the prescriber to confirm instructions for use of high-risk medicines or to escalate concerns about use of medicines for managing behaviour. If the medicine was considered to pose a risk to Mr Sharma a review with the prescriber should have been arranged.
Discussion Questions	**Care worker** Do you know who to tell if you notice something that worries you about an older person after they have taken medicines? **Clinical/ Care co-ordinator/ service manager** Is there a process for provider staff to identify and document if older people have consented to medicines?

Medication management	
	How are residential Medication Management Reviews (RMMRs) actively supported and facilitated in the service and what processes are in place to support regular review of medicines by a credentialed pharmacist? Does the provider collect data on the use of psychotropic medicines including the number prescribed for each person and the dose, frequency and duration of use for review by the Medication Advisory Committee (MAC)? **Governing Body** How is the information collected for the Mandatory Quality Indicator program, such as on the use of antipsychotics, understood and used to improve care?
 	**CCS - Appropriate reasons for prescribing** Psychotropic medicines are considered in response to behaviours only when there is a significant risk of harm to the person or others, or when the behaviours have a major impact on the person's quality of life and a reasonable trial of non-medication strategies has been ineffective. Psychotropic medicines are also considered when a mental health condition has been diagnosed or is suspected following a documented clinical assessment. The reason for use is clearly documented in the person's healthcare record at the time of prescribing. Quality statement 6 - Appropriate reasons for prescribing psychotropic medicines **CCS - Informed Consent** If psychotropic medicines are being considered, the person – and their family, support people or nominated decision-maker as appropriate – are informed about the reason, intended duration, and potential benefits and harms of treatment. Information about psychotropic medicines is presented to older people in a way they can understand. If use of a psychotropic medicine is agreed, informed consent is documented before use. In an emergency or if the person does not have capacity to decide even with support, processes are followed in accordance with relevant legislation Quality statement 2 - Informed consent for psychotropic medicines Aged Care Quality Standards **Standard 1:** Outcome 1.3 (actions 1.3.1,1.3.5, 1.3.6) **Standard 2:** Outcome 2.7 (all) **Standard 3:** Outcome 3.1 (3.1.1, 3.1.2, 3.1.3) Outcome 3.2 (3.2.4, 3.2.6, 3.2.7) Outcome 3.3 (3.3.1) **Standard 5:** Outcome 5.3 (actions 5.3.2, 5.3.4, 5.3.6) 5.4 (actions 5.4.2, 5.4.4) 5.6 (actions 5.6.3)

Managing Changed behaviours or behaviours of concern	
The Context 	The provider staff at Sunshine Care observed that Mr. Sharma's agitation worsened when he felt lonely or had not had a visitor for a while. He would call out or try to move about his room and bang on doors. He sometimes thought people were stealing his clothes and could act aggressively in response. He also sometimes refused to change his clothes so they could be washed.
The Aged Care Service	In collaboration with Mr Sharma, his daughter and others that know him well, Sunshine Care reviewed and updated the previously developed Behaviour Support Plan (BSP) to help provider staff and others that care for Mr Sharma manage his behaviours as much as possible through the use of non-medication strategies. CCS - Behaviour Support Plans This included ensuring that someone was available to speak with him on a regular basis, that his usual night-time routines were observed, that soft lighting was always used, that his photo albums were kept near his bedside and that he was regularly prompted to go to the toilet or to drink water. He liked to shower under warm water, however, as showering required staff assistance this was not always possible. CCS - Non-medication strategies The hand over for the night shift included alerting the RN if there was anything unusual for Mr Sharma during the day and there was a plan to monitor for certain symptoms including agitation, unwillingness to eat or drink, unsteadiness or reluctance to use the toilet. The Behaviour Support Plan included expanded directions about the appropriate use of PRN quetiapine for Mr Sharma. Changes to medication and non-medication strategies that support Mr Sharma were made when required, based on the observations of trained provider staff, family or reassessment with other health professionals. Mr Sharma's care plan included sleep monitoring to assess Mr Sharma's usual sleep patterns and to identify when his sleep has been disrupted. After several weeks stay at Sunshine Care provider staff observed, that Mr Sharma became restless and agitated at night, pacing around his room, and shouting out loudly. His behaviour disturbed other residents in his section, and the care staff sometimes had great difficulty in settling him using the strategies identified in his BSP and found his speech was often hard to understand. One night, Mr Sharma was particularly distressed, aggressive and with delusional signs. Provider staff had tried the non-medication strategies in his BSP without

<table>
<tr><th colspan="2">Managing Changed behaviours or behaviours of concern</th></tr>
<tr><td></td><td>success. This included conducting a pain assessment, available in the providers system, as provider staff noticed he was walking with an unusual gait. It was identified that he appeared to have mild pain in his right knee. As Mr Sharma did not otherwise seem very unwell, he was still able to walk independently, his vital signs were normal and there was no obvious redness or swelling of the knee, the provider RN administered paracetamol. This settled him temporarily and he returned to his bed.

CCS Quality Statement 3 - Assessing Behaviours</td></tr>
<tr><td>Applying the standards</td><td>In this case study Sunshine Care staff identified the non-medication strategies that worked to support Mr Sharma with changing behaviours

A Behaviour Support Plan was available in the providers care planning system to support provider staff to understand how best to support Mr Sharma

The Behaviour Support Plan was reviewed regularly to make sure the strategies it included were still relevant and supported Mr Sharma.

Sunshine care support had staff trained to assess the situation and older people with changed behaviours.

There were processes in place for handover at the end of shifts.</td></tr>
<tr><td>Strategies for improvement</td><td>Check if there are strategies in place that reduce changes in behaviour of older people with cognitive impairment

In this situation new, casual or substitute care workers need access to the information about Mr Sharma that will help them provide person centred care.

The provider could consider if the care plan is easily accessible at point of care to provider staff.

Advocating for use of a medicine to control or alter behaviour is not evidence-based practice and is against the principles of the CCS and ACQ standards.

Assessment for delirium could have been considered when his behaviours had changed.

Mr Sharma’s care plan, including his BSP should be regularly reviewed an updated with Mr Sharma, his daughter and other health professionals such as GPs when reassessments occur or when needs change.</td></tr>
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Managing Changed behaviours or behaviours of concern	
	 **Cultural safety and equity** Aged care providers need to recognise and be responsive to the cultural and linguistic needs of CALD people with cognitive disability or impairment. A variety of communication tools may be required, including working with bilingual, bicultural members of the workforce or professional interpreters across the whole service pathway, but especially during assessment and consenting processes. (*Centre for Cultural Diversity in Ageing*.)
Discussion questions	**Care worker** What do you do to find out about the older person, so you understand what is usual behaviour for them? How do you know what plans are in place to help you support an older person when there are changes in their behaviour? **Clinical/ Care co-ordinator/ service manager** What are the processes in place to alert provider staff to the best approach for each older person including how to respond to changed behaviours? How are care plans that detail the needs, goals and preferences of older people made available to provider staff? How is the need for assessment and reassessment determined? What processes are in place to access support service such as Dementia Behaviour Management Advisory Service or Severe Behaviour Response Team? What are the strategies in place if an older person refuses entry to their home, declines the service that is planned, or the provider staff feels threatened? **Governing body** How does the governing body lead and resource the organisation to prioritise behaviour support that aligns with national standards for care of people with cognitive impairment.
	CCS Quality Statement 4 - Non-medication strategies Non-medication strategies are used first-line and as the mainstay of care when responding to behaviours of concern. The choice of strategies is individualised to the person and is documented and communicated to all those involved in their care. CCS Quality Statement 5 - Behaviour Support Plans If a person has a plan to support their behaviour, it is used to inform and support their care. The person's response to care provided under the plan – including any use of psychotropic medicines – is continually assessed, documented and communicated to inform regular updates to the plan.

Managing Changed behaviours or behaviours of concern	
	CCS Quality Statement 3 - Assessing Behaviours A person with behaviours of concern is initially assessed for immediate risks to their safety and others. The person is further assessed to identify clinical, psychosocial and environmental causes of the behaviours, and to understand the context in which they occur. Assessment is conducted by suitably trained individuals and considers existing plans to support the person's care and information from others who know the person well. Aged Care Quality Standards **Standard 1:** Outcome 1.1 (actions 1.1.1, 1.1.2) Outcome 1.3 (action 1.3.6) **Standard 2:** Outcome 2.1 (2.1.3) Outcome 2.7 (2.7.1, 2.7.2) **Standard 3:** Outcome 3.1 (all) Outcome 3.2 (3.2.6) Outcome 3.3 (3.3.1) Outcome 3.4 (all) **Standard 5:** Outcome 5.1 (actions 5.1.3) 5.3 (action 5.3.4) 5.4 (all) 5.6 (actions 5.6.1, 5.6.2)

	Transitions of care
The Context 	Mr Sharma was transferred to hospital in an ambulance after falling and hitting his head. Unfortunately, the transfer summary printed by the provider was not passed onto the hospital and the hospital did not access Mr Sharma's My Health Record. It took some time for the hospital to reach Sunshine Care to get the required information. By the time of arrival at the hospital, Mr Sharma had regained consciousness but was confused, upset and very agitated. He was comprehensively assessed and diagnosed with a mild concussion. It was difficult for the hospital clinicians to establish if his behaviour was contributed to by other causes as they did not have access to complete documentation about his medical history and had to wait some time before Sunshine care was able to send the required information again. After his head injury was assessed and his wound dressed, he was discharged from the emergency department to the care of the provider. The hospital team provided a discharge summary to Sunshine Care's care coordinator, including instructions for the head wound and for review with a GP. His discharge summary was also sent to his GP.
The Aged Care Service	Prior to the transfer to hospital, Mr Sharma got out of bed and resumed shouting and banging on walls in his room. After unsuccessfully trying the non-medication strategies in his BSP without effect, and further assessing the situation, the RN administered PRN quetiapine. The RN used the prescriber's instructions on the medication chart and the processes for safe administration and documentation of PRN medicines. This eventually settled him, and he returned to his bed. Provider staff found him unconscious on the floor when they performed a check (as per the monitoring requirements in the providers protocol for PRN medicines) and immediately called an ambulance. Sunshine care had ensured that Mr Sharma's BSP, medicines list, and a transfer summary were printed and provided to the paramedics. These were available in the providers digital clinical information system and a transfer summary was available in his My Health Record. Quality statement 8 - Information sharing and communication at transitions of care

	Transitions of care
	Return to the Aged Care Service On receiving the discharge summary, the care coordinator arranged a falls assessment and an urgent review with Mr Sharma's geriatrician. However, as it was 3 weeks until the next available geriatrician's appointment, Mr Sharma had a regular appointment with his GP who reviewed his wound, conducted a general examination, commenced Mr Sharma on regular paracetamol. He also recommended that Mr Sharma be changed from PRN quetiapine to a regular dose of quetiapine with Mr Sharma's informed consent (supported by his daughter). The GP provided instructions for monitoring the effectiveness and any adverse effects of the daily dose and referred Mr Sharma for a Residential Medication Management Review (RMMR). The RN supported Mr Sharma at the appointments and followed the process to document the outcomes of the appointment in Mr Sharma's clinical information in his care plan and in the medication management system. The RN gave Mr Sharma and his daughter the information about the medicine he had been prescribed and the possible side effects verbally and in a fact sheet and asked them both if they needed any further information. His care plan and BSP were reviewed, and the effectiveness of the medication was monitored by provider staff and reviewed by the GP after 3 weeks as agreed. CCS 7 Monitoring, reviewing and ceasing psychotropic medicines
Applying the standards	**In this scenario** Sunshine care had processes in place for managing medicines safely Mr Sharma's information was shared at the transition to hospital and the discharge summary was used by the aged care provider. Transfer summaries were able to be extracted from the providers system. Provider staff were trained to assess situations for risk and conduct assessments There were processes to document and implement recommendations from health professionals
Strategies for improvement	Understand what is required to monitor and respond to older people with cognitive impairment and changed behaviours

	Transitions of care
	Consider how older people can be best supported to understand changes in their care including on return from hospital Mr Sharma's information was printed and shared with the hospital. This meant it could be misplaced between the ambulance and hospital. The provider's clinical information systems and processes could be reviewed to ensure they align with provider guidance in the Aged Care Quality Standards. Providers could demonstrate they meet such requirements by implementing a conformant digital clinical information system. In this example the provider could have considered the health support services available in the local area that may have allowed Mr Sharma to be treated at the residential care home rather than transfer to hospital. (e.g. PHN support, in-reach hospital and health services, and GP support) A plan for an assessment with a podiatrist to manage gait changes could also have been considered. **For more information**, refer to Transitions of Care | Australian Commission on Safety and Quality in Health Care
Discussion Questions	**Care Worker** How do you know if an older persons care needs have changed? How do you know what your role is in supporting older people to understand the risks and benefits of the medicines they take and the potential effects? **Clinical/ Care co-ordinator/ service manager** How are provider staff trained to monitor and document the effects of psychotropic medicines? What processes are in place if an older person refuses a review or assessment? What information is available for provider staff to use when providing information about medicines to older people? Are there processes to document consent for changes to status of medicines (e.g. PRN to daily use) medicines in the providers systems? When prescribers make a change to medicines are there processes to obtain clear instructions from prescribers, so provider staff understand how and what to monitor when older people are taking psychotropic medicines? **Governing body** How does the governing body use information from the Mandatory Quality Indicator Program such as on hospitalisation, to improve care in the service?

	Transitions of care
	Quality statement 7 – Monitoring, reviewing and ceasing A person's response to psychotropic medicines is regularly monitored and reviewed according to the person's individual needs and goals of treatment. The benefits and harms of treatment and the potential for dose adjustment or cessation are considered at each review. The outcome is documented and communicated, along with the timing of the next review. The reason for use is clearly documented in the person's healthcare record at the time of prescribing. Quality statement 8 - Information sharing and communication at transitions of care When the health care of a person is transferred, information about their ongoing needs is shared with the person, their family or support people and the healthcare and service providers continuing their care. This includes information about behaviour support plans or other strategies. If psychotropic medicines are prescribed, the reason for use, intended duration, timing of last administration, and plans for monitoring and review are documented and communicated to support the person's ongoing care. Related Outcomes Aged Care Quality Standards **Standard 2:** Outcome 2.7 (all) **Standard 3:** Outcome 3.3 (all) Outcome 3.4 (action 3.4.3) **Standard 5:** Outcome 5.1 (actions 5.1.3, 5.1.5) Outcome 5.3 (actions 5.3.1, 5.3.4) Outcome 5.4 (actions 5.4.4, 5.4.5) Outcome 5.6 (actions 5.6.1, 5.6.3) **Standard 7:** Outcome 7.2, (all)
	

Resources

1. Behaviour Support Plans | Dementia Support Australia
2. Behavioural Assessment Form (dementia.com.au)
3. Caring for Cognitive Impairment Videos - All Events (cognitivecare.gov.au)
4. Communicating for Safety | Communicating for Safety resource portal (safetyandquality.gov.au)
5. Consent for medication in aged care (agedcarequality.gov.au)
6. Clinical guidelines for dementia - Cognitive Decline Partnership Centre
7. Delirium Screen (dementia.com.au)
8. Dementia in Australia, Behaviours and psychological symptoms of dementia - Australian Institute of Health and Welfare (aihw.gov.au)
9. Dementia and psychotropic medicines - NPS MedicineWise
10. Dementia and psychotropic medicines from NPS MedicineWise
11. Dementia Training Australia (DTA), Free online courses and resources
12. Fact sheet – Medication Management in the Community | Australian Government Department of Health and Aged Care
13. Guiding principles for medication management in the community collection | Australian Government Department of Health and Aged Care
14. Inappropriate use of restrictive practices | Aged Care Quality and Safety Commission
15. Informed consent | Australian Commission on Safety and Quality in Health Care
16. Management of changed behaviour in a person with dementia (nps.org.au)
17. Medication: it's your choice - OPAN
18. Mood and behaviour changes | Dementia Australia
19. Nationwide, 24-hour dementia carer support | Dementia Support Australia
20. Parkinson's Australia - National Advocacy. Awareness. Connection.
21. Prescribing psychotropic medications to people in aged care – information and resources
22. Psychotropic self-assessment tool | Aged Care Quality and Safety Commission
23. Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard | Australian Commission on Safety and Quality in Health Care
24. Reducing inappropriate use of antipsychotics in people with behavioural and psychological symptoms of dementia (BPSD) - Infographic | Australian Commission on Safety and Quality in Health Care
25. Restrictive practices in aged care – a last resort | Australian Government Department of Health and Aged Care
26. Shared decision making | Australian Commission on Safety and Quality in Health Care
27. Strengthened Quality Standards | Aged Care Quality and Safety Commission

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

For more information

Please visit: safetyandquality.gov.au

You can also contact the project team at: agedcarestandards@safetyandquality.gov.au

safetyandquality.gov.au