

## MEGA-MAC INDICATOR 3: Admission Processes

QUM domains: Appropriate use; Safe and effective use.

### Percentage of newly admitted residents who have received recommended medicine-related admission processes

#### Purpose

This indicator assesses the presence of processes that promote quality use of medicine for newly admitted residents to residential care homes (RCHs).

This indicator is based on recommendations for medication management made in the [Guiding Principles for Medication Management in Residential Aged Care Facilities](#) (Guiding Principles) to support aged care provider organisations, residential care homes (RCHs) and aged care staff to improve medicine safety.<sup>1</sup> See Indicator Background section for more information.

#### The MEGA-MAC Indicator 3 Data Collection Tool

The MEGA-MAC Indicator 3 Excel® Data Collection Tool assists data collection and indicator calculation. The Data Collection Tool contains 8 Data Sheets to enable data collection for 8 quarters over a 2 year period. Data should only be entered into the relevant quarter's Data Sheet. The comments column in the Data Sheet can be used to make comments and/or annotate deficiencies identified during indicator measurement.

The Summary Sheet provides a summary of the auto-calculated indicator and component indicator results. No data should be entered into this sheet. Graphic displays of Indicator 3 results and those of component indicators over the audited time periods is shown and assists quality improvement evaluation. It also enables visualisation of the audit results for presentation to stakeholders such as MAC members.

The Summary of Responses Sheet displays the counts of positive responses to each statement made in the Data Sheets over the relevant quarters. No raw data should be entered into this sheet.

The MEGA-MAC Indicator 3 Data Collection Tool assists data collection and indicator calculation. The Comments column in the Data Collection Tool can be used to make comments and/or annotate deficiencies identified during indicator measurement.

**N.B. This indicator relies on documentation in the facility's clinical records. Good documentation supports quality patient care and is a critical component of optimal medication management. It is assumed that the absence of explicit documentation means no information was provided.**

#### Data collection for local use

**Inclusion criteria:** All residents (permanent and respite) who entered the RCH for the first time within the last 3 months (whether they are at the RCH or in hospital at the time of the audit). Residents who have left or have died since their RCH admission are also included.

**Exclusion criteria:** Any RCH care recipient that has resided in the RCH for over 3 months.

## Key definitions

**Newly admitted residents** refers to all residents of the RCH who have been admitted during the audited quarter. This includes:

- Respite residents,
- Non-respite or 'permanent' residents,
- Residents who have left the RCH since their admission, and
- Residents who have died since their admission to the RCH.


Throughout the Guiding Principles, activities assigned to the resident may also apply to a family member, carer and/or substitute decision maker, depending upon the resident's circumstances.<sup>1</sup> A substitute decision-maker (who may also be a family member and/or carer) should be nominated when a resident cannot make decisions on their own or without support. The terms used to describe the substitute decision-maker may vary between RCHs and jurisdictions. The 'Next of Kin' or 'Person Responsible' is not a substitute decision-maker unless there is explicit documentation that the substitute decision-maker role has been assigned to this person.


**Recommended medication-related admission processes** refers to the following processes having been completed and documented within two weeks of the resident entering the RCH. It is also acceptable if some processes occur during pre-admission assessment before admission to the RCH.

### 1. The resident was asked about their medicine needs, preferences and medicine-taking behaviours at admission.

This means there is explicit documentation within RCH form(s)/clinical notes that the resident (or their carer/ family member/ substitute decision-maker) was asked regarding ALL of the following:

- The resident's drug allergies/sensitivities. When the resident does not have any allergies or drug sensitivities, documentation should state 'No known allergies', 'NKA' or similar terminology.
- The resident's preferred time of day to take their medications.
- Whether the resident wishes to self-administer\* any of their medications in the RCH. This means that there should be documentation outlining that the resident (or their carer/ family member/ substitute decision-maker) was asked whether the resident wishes to self-administer and the response to this question. All residents (or their carers/ family members/ substitute decision-makers) should be asked about their wish to self-administer irrespective of the resident's cognitive status or perceived capacity to self-administer one or more of their medicines. The Data Collection Tool for this indicator requires you to enter both pieces of information. The possible responses for this item are, 'yes, nominated to self-administer', 'yes, nominated NOT to self-administer' and 'no, resident was not asked'.
- Whether the resident reports any difficulty swallowing medicines including whether any oral medicines were dispersed, crushed or modified before they were admitted to the RCH. This means that there should be documentation outlining that the resident (or their carer/ family member/ substitute decision-maker) was asked whether the resident has any difficulty swallowing medicines and the response to this question. The Data Collection Tool for this indicator requires you to enter both pieces of information. The possible responses for this item are, 'yes, reported difficulty swallowing medicines', 'yes, reported NO difficulty swallowing medicines' and 'no, resident was not asked'.

 Allocate a 'Yes' response in the Data Collection Tool to each of the items above if there is documentation showing the resident (or their care/ family member/ substitute decision-maker) was asked about each item. N.B. The request for information from the residents (or their carers/ family members/ substitute decision-makers) for each of these statements is required regardless of cognitive capacity.

 Allocate a 'No' response in the Data Collection Tool to each of the items in the Data Collection Tool if there is no documentation showing that the resident (or their carer/ family member/ substitute decision-maker) was asked about an item.

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\*Self-administration of medicines refers to the resident independently taking/using medications that are written up on the medication chart by a prescriber, usually the general practitioner. Self-administering is not the same as self-medicating. Self-medicating refers to the act of the resident selecting medicines to take/use.

## 2. When the resident nominated to self-administer, the resident's capability to self-administer medication was assessed.

This means that when a resident nominates to self-administer one, some or all of their medications, there is explicit documentation that the resident has been assessed using a comprehensive structured process that demonstrates that self-administration presents no harm to themselves or others.

An example of a comprehensive structured process would generally include but is not necessarily limited to the individual resident's ability to:

- identify medications they wish to self-administer,
- open boxes, foil packs, bottles and/or dose administration aids (DAAs) containing medications chosen for self-administration,
- indicate when medications chosen for self-administration should be taken/used,
- obtain the correct dose of medication they wish to self-administer, and
- safely store their medications for self-administration (e.g. in a locked drawer and in a locked room when the resident is absent).

The resident may self-administer some or all of their medications using individual medicine containers or medications may be assembled in DAAs.

For those who nominated to self-administer one or more of their medications:



Allocate a 'Yes' response in the Data Collection Tool when self-administration assessment uses a comprehensive structured process to assess the individual resident's capability to self-administer their medication(s) AND the relevant assessment questions have been completed.



Allocate a 'No' response in the Data Collection Tool when a comprehensive structured assessment process is not used OR when one or more of the relevant assessment questions have not been answered.



A grey cell (equivalent to a 'N/A') will be automatically allocated in the Data Collection Tool when the resident:

- did not wish to self-administer any of their medications, OR
- was not asked if they wished to self-administer any of their medications (as per Statement 1c).

## 3. When the resident reports swallowing difficulties, their oral medications within their medication regimen have been assessed for appropriateness.

Assessment of appropriateness of the medicine formulations means that there is explicit documentation that evaluation has occurred regarding the suitable dispersion/crushing /modification of any of the resident's oral medications.

Evaluation would ensure that a suitable dosage form is being used and crushing/dispersion of solid dosage forms or modification (e.g. thickening) of oral liquid medicine formulations is undertaken as recommended by an appropriate reference text e.g. 'Don't Rush to Crush'.<sup>2</sup>

This assessment may be undertaken by the pharmacist, general practitioner, nurse practitioner or registered nurse. Documentation about this assessment may be located in doctor's, pharmacist's or nursing assessment or progress notes, medication care plans, and medication administration charts. This indicator does not require assessment by a speech pathologist although this may also occur, especially when there are difficulties swallowing food and drink.

For those reported difficulty swallowing medicines:



Allocate a 'Yes' response in the Data Collection Tool when there is documentation that **all** oral medication formulations were assessed for their appropriateness for oral administration including suitability for dispersion, crushing or modification.



Allocate a 'No' response in the Data Collection Tool if there is no explicit documentation that all oral medication formulations were assessed for their appropriateness for oral administration including suitability for dispersion, crushing or modification.



A grey cell (equivalent to a 'N/A') will be automatically allocated in the Data Collection Tool when the resident:


- did not report difficulties swallowing medicines or was not crushing/dispersing/modifying any oral medications before RCH admission, OR
- was not asked about swallowing difficulties pre-RCH admission (as per Statement 1d).


#### 4. The resident's vaccination status.

This means that there should be documentation showing the month and year when the resident last received their influenza and COVID-19 vaccination.

This documentation should state:


- when the resident was last vaccinated against influenza and COVID-19 (month/year), or
- in the case of COVID-19 vaccination, when the resident was last diagnosed with a COVID-19 infection (month/year) if more recent than COVID-19 vaccination, or
- when the resident (or substitute decision-maker) has refused vaccination (e.g. 'vaccination refused' or similar terminology).


 Allocate a 'Yes' response in the Data Collection Tool when there is documentation of the resident's influenza and COVID-19 vaccination status.

 Allocate a 'No' response in the Data Collection Tool when there is no explicit documentation related to vaccination status as above or the vaccination status is stated to be unknown.

#### 5. The resident has a person nominated to assist medicines-related decision-making (i.e. themselves or a substitute decision-maker).

Medicine-related decision-making is required for developing, implementing and reviewing individualised care plans. A person has the right to partner in their care to the extent that they choose. A resident with the capacity to make medicines-related decisions may nominate themselves. A substitute decision-maker (who may also be a family member and/or carer) may be nominated when a resident cannot make decisions on their own or without support. The terms used to describe the substitute decision-maker may vary between RCHs and jurisdictions. The 'Next of Kin' or 'Person Responsible' is not a substitute decision-maker unless there is explicit documentation that the substitute decision-maker role has been assigned to this person.

 Allocate a 'Yes' response in the Data Collection Tool when there is a person nominated to assist with decision-making i.e. a resident has nominated themselves or a substitute decision-maker has been nominated.

 Allocate a 'No' response in the Data Collection Tool when NO person has been nominated to assist medication-related decision-making i.e. the resident or a substitute decision-maker.

## Recommended data sources

The relevant information should be located in the resident's pre-admission/pre-accommodation and/or admission clinical records at the RCH. Data collection will be assisted by the RCH providing a list of newly admitted residents.

The data sources for substitute decision-maker information may vary between RACFs e.g. there may be an explicit entry for a substitute decision-maker in the RACF forms/software or a nomination may have been made in the resident's Advanced Care Directive.

## Calculation of Indicators

$$\frac{\text{Numerator}}{\text{Denominator}} \times 100\%$$

The use of this indicator and the accompanying Data Collection Tool enables calculation of the summary Indicator and the component Indicators. These will assist monitoring and development of quality improvement strategies.

Indicators	Numerator	Denominator	Target
<b>Summary Indicator</b>			
Percentage of newly admitted residents who have received recommended medicine-related admission processes.	Number of residents admitted within the audited quarter with recommended medicine-related admission processes.	Number of residents admitted within the audited quarter.	<b>High (towards 100%)</b>
<b>Component Indicators for medication-related processes documented at admission</b>			
1. Percentage of newly admitted residents who have their medicine needs, preferences and medicine-taking behaviours documented.	Number of residents admitted within the audited quarter who have their medicine needs, preferences and medicine-taking behaviours documented.	Number of residents admitted within the audited quarter.	<b>High (towards 100%)</b>
2. Percentage of newly admitted residents wishing to self-administer medicines who were assessed for their capability to self-administer medications.	Number of residents admitted within the audited quarter wishing to self-administer any of their medications who have their ability to self-administer these medication(s) assessed.	Number of residents admitted within the audited quarter who wish to self-administer any of their medications.	<b>High (towards 100%)</b>
3. Percentage of newly admitted residents with swallowing difficulties whose oral medications within their medication regimen were assessed for appropriateness.	Number of residents admitted within the audited quarter with swallowing difficulties whose oral medications within their medication regimens were assessed for appropriateness.	Number of residents admitted within the audited quarter with swallowing difficulties.	<b>High (towards 100%)</b>
4. Percentage of newly admitted residents whose vaccination status is documented.	Number of residents admitted within the audited quarter who had their vaccination status for influenza and COVID-19 documented.	Number of residents admitted within the audited quarter.	<b>High (towards 100%)</b>
5. Percentage of newly admitted residents who have nominated a person to assist with medicines-related decision-making.	Number of residents admitted within the audited quarter who have nominated a person to assist medicines-related decision-making.	Number of residents admitted within the audited quarter.	<b>High (towards 100%)</b>

## Indicator Limitations

Data collection involves collating several components of appropriate admission medication-related processes. The measurement of the individual components informs post-audit interventions. This indicator does not measure the quality of the assessments, or the healthcare professionals assigned to undertake the assessments. This information may be useful for post-audit interventions.

## Indicator Background

The Guiding Principles for Medication Management in Residential Care homes (Guiding Principles) set out recommendations for medication management to support aged care provider organisations, residential care homes (RCHs) and aged care staff to improve medicine safety.<sup>1</sup>

It is recommended that RCHs should provide person-centred care, respond to residents' needs and preferences, guide residents who self-administer their medications and support residents who have swallowing difficulties. These processes are well placed to occur during the admission process.

This indicator is based on recommendations in:

- Guiding Principle 1: Person-Centred Care,
- Guiding Principle 6: Selection of Medicines,
- Guiding Principle 10: Medication Reconciliation,
- Guiding Principle 14: Self-Administration of Medicines, and
- Guiding Principle 15: Administration of Medicines by Nurses.

Guiding Principle 1 outlines considerations to promote person-centred care including the involvement of a person's carers (external to the RCH) and family. RCHs are encouraged to consider how carers, family and/or substitute decision-makers are included in the decision-making about an individual's treatment options and choices. When a resident lacks the capacity to consent to a decision, aged care providers have a responsibility to know who the substitute decision maker is and the types of decisions they are authorised to make on behalf of the person.<sup>3</sup>

Guiding Principle 6 promotes a quality use of medicines (QUM) approach by the RCH to the safe and appropriate selection, use and management of medicines. Knowing the immunisation status of the resident on admission assists the RCH in understanding the risk communicable diseases pose for the individual, the RCH workforce and the RCH, promotes evidence-based immunisation practice and enables RCH planning for local and/or population disease outbreaks. All RCHs have explicit obligations under the Aged Care Quality Standards to have infection prevention and control (IPC) programs in place.<sup>4</sup> Identification of immunisation status should be undertaken during medication reconciliation processes at transitions of care (Guiding Principle 10).

Guiding Principle 14 states a person who wishes to administer their medicines themselves, needs to be formally assessed to determine the risk to themselves or others, including the person's capacity to self-administer medicines safely. In a RCH, the person's consent must be obtained to do so.

Swallowing difficulties are common in people receiving care in RCHs. Guiding Principle 15 recommends RCHs consider their processes for assessing an individual's ability to safely swallow their medicines upon admission and arising from any change in the person's condition or ability to swallow.

A person receiving short-term respite should receive the same care as that provided to others receiving care within the RCH. This includes supporting a person to self-administer their medicines if that is their preference and they are capable of doing so.<sup>1</sup>

## Further information

This indicator can be used to assist RCHs in meeting the Strengthened Aged Care Quality Standards<sup>3</sup>, in particular:

- i) Standard 1: The Individual. Outcome 1.1: Person-centred care; Outcome 1.3: Choice, independence and quality of life.
- ii) Standard 2: The Organisation. Outcome 2.1 Partnering with individuals; Outcome 2.2b: Quality, safety and inclusion culture to support individuals; 2.3: Accountability, quality system and policies and procedures; Outcome 2.4: Risk management.
- iii) Standard 3: The Care and Services: Outcome 3.1: Assessment and planning; Outcome 3.2: Delivery of funded aged care services; Outcome 3.3: Communicating for safety and quality; Outcome 3.4: Planning and coordination of funded aged care services.
- iv) Standard 4: The Environment. Outcome 4.2: Infection prevention and control.
- v) Standard 5: Clinical care. Outcome 5.3: Safe and quality use of medicines; Outcome 5.4: Comprehensive Care; Outcome 5.5: Safety of clinical care services.
- v) Standard 7: The Residential Community. Outcome 7.2: Transitions.

## References

1. *Guiding Principles for Medication Management in Residential Care homes*. Commonwealth of Australia, Dept of Health and Aged Care; 2022. Accessed July 1, 2024. <https://www.health.gov.au/resources/publications/guiding-principles-for-medication-management-in-residential-aged-care-facilities?language=en>
2. The Society of Hospital Pharmacists of Australia. *Don't Rush to Crush*. Fourth Edition. Victoria, Australia. 2021.
3. Aged Care Quality and Safety Commission. Frequently asked questions about consent. [https://www.agedcarequality.gov.au/sites/default/files/media/frequently-asked-questions-about-consent\\_0.pdf](https://www.agedcarequality.gov.au/sites/default/files/media/frequently-asked-questions-about-consent_0.pdf)
4. *Strengthened Aged Care Quality Standards (draft)*. Commonwealth of Australia, Dept of Health and Aged Care; 2025. Accessed 29 March, 2025. <https://www.health.gov.au/resources/publications/strengthened-aged-care-quality-standards-february-2025?language=en>