Stroke Foundation response to online survey questions for AHRPA consultation on the revised National Prescribing Competencies Framework

About Stroke Foundation

Stroke Foundation is a national charity that partners with the community to prevent stroke, save lives and enhance recovery. We stand alongside survivors of stroke and their families, healthcare professionals and researchers. We build community awareness, foster new thinking, and support survivors on their journey to live the best possible life after stroke.

Question 1

The revised framework puts the person receiving care at the centre of the prescribing process, particularly people with specific needs. Do you have any feedback on the framework structure?

Stroke Foundation puts those with a lived experience of stroke, including survivors of stroke, their families and carers, at the centre of everything we do. This ensures that our work is relevant, inclusive, accessible, and meets the actual needs and preferences of those with lived experience, ultimately leading to better outcomes. Therefore, we strongly support the revised Framework putting the person receiving care at the centre of the prescribing process.

After an initial stroke, the 10-year cumulative risk of a subsequent stroke is almost 40 percent in those who survive, with the highest occurrence in the first 12 months (11 percent). Importantly, while recurrent stroke is common, it is often preventable, and the Living Guidelines for Stroke Management recommend a range of secondary prevention strategies, including the use of antithrombotic therapy, and blood pressure lowering and cholesterol-lowering medications, which should be started immediately and continued indefinitely. In addition, medications are commonly used for the management of comorbidities (e.g., coronary heart disease, diabetes and depression) and secondary conditions (e.g., chronic pain) related to stroke. Notably, while optimal medication self-management is critical to reducing the risk of recurrent stroke, for many survivors of stroke, medication adherence is often poor.

Survivors of stroke, particularly those living alone with limited support, are most vulnerable to avoidable medication adherence problems in the weeks following hospital discharge, when they are required to rapidly adapt to the practical challenges of managing multiple medications, often with little or no preparation. Key activities that are part of this transition include taking medications on schedule, organising and undergoing necessary blood tests, initiating medication reviews, and organising and obtaining repeat prescriptions.

There are a number of factors that are known to impact medication adherence and self-management following stroke, including polypharmacy (use of multiple medications, often five or more) which often increases the complexity of a medication regimen, receipt of medication education/instructions, medication-related supports (e.g., pillboxes and blister packs), affordability, and health professional knowledge. An individual's knowledge, beliefs and concerns about medications can also have a major impact on their adherence to prescribed treatments. For example, as a result of mistaken beliefs about medications, due to misinformation from a range of sources, patients may think they are unsafe or ineffective, question their necessity, or choose not to take them as prescribed. It is important that these false beliefs are dispelled by health professionals through targeted patient education. Further to this, stroke-related cognitive, communication and functional deficits may also impact an individual's ability to self-manage their medications.

The development of effective strategies to improve medication adherence is key. Person-centred care, which is focused on delivering care in a way that is responsive to individual patient preferences, needs, beliefs, goals, and values, has been shown to support appropriate medication prescribing and use. *As such, Stroke Foundation strongly supports expanding on the person-centred approach in the revised Framework.*

Health literacy, the cognitive and social skills required to gain access to, understand and use information in order to promote and maintain good health, has been recognised as an important foundation for successful and continuous self-management. Competency 3.2 in the revised Framework states that the prescriber can develop the therapeutic goals in partnership with the patient to enhance self-management and health literacy, and *Stroke Foundation supports this emphasis on the importance of a person's health literacy when prescribing.*

People living in the lowest socioeconomic areas are more than 2 times as likely to experience, and 1.3 times as likely to die from stroke, as those living in the highest socioeconomic areas. In the current cost of living crisis, the affordability of medicines is becoming an increasingly important issue. *As such, Stroke Foundation is pleased to note a consideration of the financial cost and affordability of medicines to the patient, in Competency 2.8 in the revised Framework.*

Finally, we know that the impact of stroke is greater in Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, older people in residential aged care, and those living in regional, rural and remote communities. *Therefore, Stroke Foundation is supportive of the increased focus on these, and other vulnerable groups with specific needs, in the revised Framework.*

Question 2

The revised framework aims to empower a person to actively participate in shared decision-making about treatment options with their health professionals. Do you agree with this? Why/Why not?

Stroke Foundation strongly supports the revised Framework's focus on shared decision making (SDM), which is a crucial part of delivering person-centred care, and has been shown to improve satisfaction with care and lead to better-quality decisions. For survivors of stroke however, it is critical that strategies are in place that address specific needs they may have as a consequence of stroke-related cognitive, communication or functional deficits, to facilitate and optimise their participation in SDM.

SDM, where health professionals share the best available medical evidence with patients (and their families and carers where appropriate), and support them to choose the best treatment option for them (including no treatment), in line with their own beliefs, values, goals and preferences, is central to person-centred care. This approach enables patients to balance the potential benefits and harms of different treatment options, as well as considerations such as mechanism of administration, invasiveness, cost and side effect profile.

Research has identified a wide variety of benefits of SDM for patients, including improved knowledge/understanding, satisfaction, trust, treatment adherence and health outcomes. SDM can also result in benefits for the healthcare system, such as improved satisfaction among health professionals and optimal resource utilisation. *Therefore, Stroke Foundation strongly supports the increased emphasis on SDM between the person receiving care and the prescriber, in the revised Framework.*

It is important to acknowledge however, that there are a number of challenges or barriers to practising SDM more broadly, and with survivors of stroke specifically.

Some of the barriers to practising SDM include negative health professional and patient attitudes about SDM. For health professionals, a lack of familiarity and experience with SDM, and a lack of understanding of its benefits, can also be important barriers. A good relationship between health professionals and patients is key, with SDM most likely to succeed in settings where there is a trusting, established relationship, and the health professional understands the patient's background, values and goals. It is critical that consultations allow enough time for health professionals to provide sufficient information and explanations, using plain language, and that patients are encouraged to participate and ask questions.

For survivors of stroke, cognitive problems (e.g., memory problems or the inability to adequately exercise their judgement), or communication problems (e.g., aphasia) can limit their understanding of complex information about treatment options and their expected outcomes, and therefore hinder their participation in the SDM process. Importantly, the presence of cognitive or communication problems does not necessarily preclude patients from participating in SDM, and there may be specific adjustments that can be made, or strategies that can be adopted, in order to facilitate their involvement in the decision-making process. For example, decision aids, tools that guide patients, families and health professionals through the SDM process, often using visual aids, may be used. Alternatively, where a patient is incapacitated and unable to participate, a surrogate decision maker, often a family member, will need to be involved; however, they may not necessarily be aware of the patient's views, values, beliefs and preferences, making participation in SDM challenging.

Question 3

Is there anything else that the framework should cover for the public or are there other considerations that we may have missed?

We know that in Australia, inadequate discharge communication between acute and primary care, can have serious consequences for survivors of stroke, including adverse medication events. Therefore, Stroke Foundation recommends that for survivors of stroke who are discharged home from hospital on multiple medications, a routine home medicines review by a pharmacist should be undertaken, so they (and their families and carers) have the information they need to clearly understand their medication regimen.

For a variety of reasons, Australian survivors of stroke, many of whom have complex needs, are increasingly discharged home from hospital, rather than to a rehabilitation facility. Therefore, the provision of adequate information and communication to survivors, their families and carers, and the health professionals responsible for caring for them after discharge, is critical to a smooth transition between hospital and the community. Importantly however, this does not always occur.

Evidence suggests that in Australia, communication and the transfer of information between hospitals and primary care is often disconnected, and inadequate for the complex care and recovery needs of survivors of stroke. Inadequate discharge communication and documentation between acute and primary care, and the resultant discontinuity of care, can have serious consequences, including post-discharge adverse events and possible readmission to hospital. Survivors of stroke in particular may be more vulnerable to poor outcomes as a result of failures in discharge planning, due to the cognitive and functional disability many experience post-stroke.

Once at home, following discharge from hospital, there are a number of challenges survivors of stroke may face with regard to their prescribed medications, due to stroke-related cognitive and functional deficits. These include difficulties remembering to take medications, recent medication changes, and the risks associated with their medications, as well as problems opening medication packaging, measuring dosages, and attending appointments to have blood tests (e.g., international normalised ratio testing to monitor warfarin therapy). Further to this, they may be using non-prescription agents such as supplements that could be contraindicated, or reduce the efficacy of their prescription medications. Therefore, strategies are needed to ensure survivors of stroke (and their families and carers) have the information they need to clearly understand their medication regimen once they are discharged home.

Competency 5.5 in the revised Framework states that the prescriber can discuss with the patient the benefits of a *medication management review*, where appropriate (e.g., where the patient is taking multiple medicines regularly, has had significant changes to their medicines plan, has difficulty managing their medicines, or if it appears the patient may not be adhering to their medicines plan). This includes a *Home Medicines Review*, where an accredited pharmacist conducts a comprehensive clinical review of their medicines in the patient's home, to ensure they have a thorough understanding of their medication regimen and are managing their medications effectively. The outcome of the review is shared with the patient (and their carer where appropriate), as well as members of their healthcare team. This service is focused on enhancing the quality use of medicines, reducing the risk of harmful side effects, and improving medication adherence.

It has been suggested that for survivors of stroke who are prescribed lipid lowering and/or blood pressure medications, discharge from hospital is an appropriate trigger for a home medicines review by a pharmacist.[1] The routine request for a home medicines review would enable the patient's medication list to be reconciled against the medications they are actually taking, and would facilitate other compliance checks for issues such as drug–drug interactions and anticholinergic load. This has the potential to improve continuity of care and patient safety, and reduce the risk of poor patient outcomes and strain on carers.

The Framework will be used to inform the development of education and training programs and continuing professional development (CPD) programs. As such, there is an opportunity for the relevant professional bodies representing each of the key health professional groups involved in the treatment and care of survivors of stroke, to include information on the routine request for home medicines reviews for survivors as part of their education, training and CPD programs.

References

1. Kable A, Pond D, Baker A, Turner A, Levi C. 2018. Evaluation of discharge documentation after hospitalization for stroke patients discharged home in Australia: A cross-sectional, pilot study. Nursing and Health Sciences. 20:24-30.