SHPA Queensland Branch Committee response to Proposed changes to QScript look-up requirements and the Monitored Medicines Standard, February 2024

Consultation questions for proposed changes to QScript look-up requirements

1. Please identify the extent to which you support or oppose each of the proposed exemptions to the mandatory checking of QScript for relevant practitioners

Proposed exemptions	**Oppose** exemption	**Neither support nor oppose** exemption	**Support** exemption **(with changes)**	**Support** exemption **(as is)**	**Not sure / don't know**
Persons being **prescribed a monitored medicine for administration**	☐	☐	☐	☒	☐
Patients receiving treatment in a **hospital** (except on discharge)	☐	☐	☒	☐	☐
Residents being treatment in a **residential aged care facility**	☐	☐	☐	☒	☐
Prisoners being treated in a **correctional facility** or detained persons being treatment in a **watchhouse (**except on release)	☐	☐	☐	☒	☐
Persons being provided a monitored medicine for **end-of-life-care**	☐	☐	☒	☐	☐
Persons who have been assessed to be **eligible for access to voluntary assisted dying**	☐	☐	☐	☒	☐
Persons being provided **emergency treatment** (regardless of care setting)	☐	☐	☐	☒	☐

2. If you would like to elaborate on your responses or provide general feedback, please do so here:

Patients receiving treatment in a hospital (except on discharge)

QScript is an important system in reducing potential harm caused by monitored medicines in Queensland. During a patient's admission, every effort should be made to identify the risk of misuse of monitored medicines as early as possible. If present, this risk should be a consideration when prescribing monitored medicines during admission through to discharge planning. While SHPA supports the exemption of

mandatory QScript checking for inpatients, especially in emergency settings, all reasonable steps should be taken to ensure QScript is checked earlier during admission to ensure risk of harm due to inappropriate prescribing of monitored medicine is identified and mitigated.

Persons being provided a monitored medicine for end-of-life care

There needs to be a standardised process to identify if a person is being provided a monitored medicine for end-of-life care, as currently there is no process for dispensing practitioners (e.g. community pharmacists) to determine whether a presented prescription is for use in palliative or end-of-life-care. A potential solution to this would be a notification system for both the prescription and in QScript, similar to the system implemented in South Australia where prescriptions intended for palliative care are endorsed as 'Notified Palliative Care patient' (NPCP) by the prescriber.

Additionally, the end-of-life-care trajectory for some patients may be longer than 12 months where they remain functionally debilitated but experience a slower disease progression, and this is particularly difficult to prognosticate in non-malignant diseases. There needs to be flexibility in the definition of end-of-life care to include palliative care patients where care has extended beyond 12 months for an individual, to avoid confusion for prescribers and dispensers.

3. What changes, if any, do you believe should be made to the proposed exemptions, and why?

As mentioned earlier, SHPA recommends that a process is implemented for prescriptions intended for palliative care or end-of-life care to be endorsed as such on prescriptions for dispensers. Monitored medicines are prescribed in combinations and doses that are unconventional in routine care. Pharmacists as advocates for quality and safe use of medicines may deem this as inappropriate prescribing of monitored medicine, if they are not aware of the context of use, in this care for palliative or end-of-life care.

SHPA members report that there have been scenarios where patients have presented with benzodiazepine or gabapentinoid prescriptions to a pharmacy and was subsequently informed by a community pharmacist that the combination of benzodiazepines with their usual opioid prescription would be dangerous and have been advised against taking both.

While this may be an appropriate advice to give in routine care, higher opioid doses, and combined use of opioids with benzodiazepines and gabapentinoids are commonly observed in the treatment of palliative and end-of-life care patients. To avoid confusion for both relevant practitioners and patients receiving care, appropriate systems to flag such prescriptions should be implemented.

4. The draft definition of 'a person being provided a monitored medicine for **end-of-life care** is:

A person who has been diagnosed with a disease, illness or medical condition that is advanced, progressive and is expected to cause death within 12 months, who is being prescribed or supplied a monitored medicine for palliative treatment.

Do you consider this definition to be appropriate?

As previously discussed in the exemption for persons being provided a monitored medicine for end-of-life care, it is important to ensure flexibility in the definition to include exemptions for end-of-care patients whose disease trajectory is prolonged beyond 12 months. SHPA suggests adding further to the definition to include a

statement, “for some patients, end-of-life care may extend beyond 12 months depending on disease or illness trajectory”.

Consultation questions for proposed changes to the Monitored Medicines Standard (MMS)

	Oppose exemption	**Neither support nor oppose** exemption	**Support** exemption **(with changes)**	**Support** exemption **(as is)**	**Not sure / don’t know**
Please identify the extent to which you support or oppose the proposed amended MMS	☐	☐	☐	☒	☐

1. If you would like to elaborate on your responses or provide general feedback, please do so here:

For palliative care patients, benzodiazepines and gabapentinoids are commonly co-prescribed with opioids, and total daily opioid dose is often greater than 100 mg oral morphine equivalent (OME) for those with advanced disease. These proposed changes will alleviate concerns or unwillingness of some general practitioners to provide ongoing prescriptions for monitored medicines, and/or requesting Authority for increased quantities where clinically indicated. The proposed changes will also significantly streamline workflow for both prescribers and dispensers, especially as it is common for patients to have monitored medicines prescribed by several unique prescribers if they are under the care of multiple hospital speciality teams, frequently being seen by different members of each team at each appointment.

2. What changes, if any, do you believe should be made to the proposed amended MMS, and why?

No further comments

3. If you have any further comments about the proposed QScript look-up exemptions or amended MMS, please record them here.

The Society of Hospital Pharmacists of Australia (SHPA) is the national, professional organisation for the 6,100+ Hospital Pharmacists, and their Hospital Pharmacist Intern and Hospital Pharmacy Technician colleagues working across Australia’s health system, advocating for their pivotal role improving the safety and quality of medicines use. Embedded in multidisciplinary medical teams and equipped with exceptional medicines management expertise, SHPA members are progressive advocates for clinical excellence, committed to evidence-based practice and passionate about patient care.