SHPA ACT Branch Submission to Medicine Authorisations in the ACT, August 2022

The Society of Hospital Pharmacists of Australia is the national professional organisation for more than 6,100 pharmacists and their pharmacist technician and intern pharmacist colleagues, working across Australia's hospitals and healthcare system. SHPA members are progressive advocates for clinical excellence, committed to evidence-based practice and passionate about patient care.

On behalf of the SHPA ACT Branch, chaired by Melissa Faehrmann, SHPA welcomes the opportunity to provide input to the Medicine Authorisations in the ACT consultation paper.

Issue 1: Allied Health Professional (AHP) medicine authorisations at public institutions

SHPA provides in principle support for option 1 to *'Amend the Medicines, Poisons and Therapeutic Goods (MPTG) Regulation to enable the CEO of a public institution to authorise AHPs to obtain, possess, supply and administer medications.'*

Alleviating pressures on ACT hospitals with Partnered Pharmacist Medication Charting (PPMC) model

In the current health system climate, there are known pressures throughout the hospitals and healthcare system with unprecedented demands on resources. SHPA welcomes increasing the scope of practice of appropriately trained and credentialed Allied Health Professionals (AHP), alleviating these pressures on medical and nursing colleagues and to better facilitate and increase the flow through of patients in the hospital.

The hospital admission process in emergency departments can often be a barrier to efficient bed flow, with the need to undertake a patient's medication history and chart their medicines being a task that doctors have to juggle and balance along with their responsibilities. Pharmacists are able to take more accurate medication histories in a timelier manner than their nursing and medical colleagues in hospitals, and when supported to chart these medicines via a PPMC model, can contribute to efficiencies in medication charting, supply and administration whilst also freeing up capacity for nurses and doctors to spend more time with patients. Hospital Pharmacists already supervise and train junior doctors in prescribing and advise senior medical staff on medicine and treatment selection, dosing, medicine administration requirements and monitoring of adverse effects.

PPMC has already been implemented in Victoria, Queensland and Western Australia. In a PPMC model, a pharmacist conducts a medication history interview with a patient; develops a medication plan in partnership with the medical team, patient, and the treating doctor. The pharmacist then charts the patient's regular medications with the doctor's authorisation, and the doctor charts any new medications that are initiated in hospital.

Using a PPMC model will decrease the burden upon medical staff and clinical resourcing dedicated to medication charting and increase the through put of patients if medications are already reviewed and charted prior to admission and ready for review by the admitting medical or surgical team. This model can not only lay the foundations for the proposal outlined in this consultation for AHPs to supply and administer medications but has also been shown to improve medication safety and patient care.

A Deakin University health economic evaluation[1] of more than 8,500 patients has explored the impacts of PPMC models upon patients in emergency departments and general medicine wards. The economic evaluation also showed a decrease in the proportion of patients with at least one medication error from 19.2% to 0.5% and a reduction in patient length of stay from 6.5 days to 5.8 days. The estimated savings per PPMC admission was $726, which in the replication was a total hospital cost saving of $1.9 million with the five health services involved in the PPMC service continuing their operations.

Other protocols under the PPMC model that could improve quality, safety and efficiency include:

- Therapeutic Drug Monitoring (TDM) protocols for charting appropriate antimicrobial therapy according to cultures, including intravenous therapy to oral step down
- Anticoagulant stewardship and Venous Thromboembolism (VTE) prophylaxis
- Opioid analgesic stewardship through pharmacist-led de-escalation of opioids in orthopaedic patients
- Charting medicines according to established medicines prescribing protocol for common conditions or indications, as reviewed and approved by the Medicines and Therapeutics Committee

An example where PPMC could enable this proposal would be that an orthopaedic patient is required to mobilise with their physiotherapist. However, they do not have the appropriate analgesia charted. Under a PPMC model, in discussion with the treating doctor, a pharmacist could review and chart the appropriate analgesia, the physiotherapist under the AHP medicine authorisation proposal could then supply and administer the analgesia to the patient. In this example, a doctor was not required to chart the medication and a nurse was not required to administer it, fulfilling the purpose of this proposal. The PPMC model has also been shown to be well received in medical staff satisfaction surveys.[2]

PPMC supports timelier, safer and improved quality care for patients, and increases capacity for doctors to spend more time with patients. Hospital pharmacists have been demonstrated to be able to provide clinical expertise and services to achieve these outcomes whilst reducing the administrative and clinical burdens upon the medical workforce.

Medication Safety Considerations

With in-principle support for issue 1, option 1, SHPA recommends the appropriate oversight of medicine authorisations and AHPs scope of practice by Medicine and Therapeutics Committee or equivalent to provide assurance that patients not only receive medications in a timely manner but also with appropriate consideration for medication safety. In addition to the tertiary education in Pharmacology required for medicine authorisation to be granted to AHPs, SHPA recommends that the clinical education and training should be provided by pharmacists as well as medical staff. This would ensure that AHPs are adequately supported in expanding their scope of practice into the practical aspects of medication handling, safety, storage, and administration. SHPA supports the proposal of medicines authorisations applying to the specific clinical settings stipulated in the framework.

Issue 2: Medicine authorisations for registered nurses (RNs) and registered midwives (RMs) at public institutions

SHPA provides in principle support for option 2 to *'amend the MPTG Regulation to enable medications to be supplied under standing orders at institutions.'*

With the appropriate oversight by a Medicine and Therapeutics Committee, it should be determined which medicines RN and RMs can supply. SHPA suggests that the Medicine and Therapeutics Committee should implement additional controls such as the patient being seen by a doctor within a given period of time following the supply of medication under the standing order.

If you have any queries or would like to discuss our submission further, please do not hesitate to contact Jerry Yik, Head of Policy and Advocacy on jyik@shpa.org.au.

References

[1] Deakin University.(2020). Health Economic Evaluation of the Partnered Pharmacist Medication Charting (PPMC) program. Available at: https://www.safercare.vic.gov.au/improvement/projects/mtip/ppmc

[2] Khalil, V., deClifford, J.M., Lam, S. and Subramaniam, A. (2016), Implementation and evaluation of a collaborative clinical pharmacist's medications reconciliation and charting service for admitted medical inpatients in a metropolitan hospital. Journal of Clinical Pharmacy and Therapeutics, 41: 662-666. https://doi.org/10.1111/jcpt.12442