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Pharmacist Prescribing in Australia

The health system in Australia is showing stress from an ageing population, increase in chronic diseases and a reduced ability for the public to easily access doctors. To add to the stress, it is predicted that the shortage in general practitioners in Australia will continue.¹ These pressures highlight the need for the development of new primary care models.

Australian pharmacists wish to further utilise their extensive drug and therapeutics knowledge to enhance patient care. The continuing 'down-scheduling' of prescription-only medicines in Australia is making an increasing range of medicines available for community pharmacists to prescribe over-the-counter. A logical expansion of this phenomenon and other patient-focused services provided by pharmacists is to extend prescribing by pharmacists to a broader range of medicines. Pharmacists in the UK have achieved this objective with the introduction of supplementary (dependent) prescribing in 2003 followed by independent prescribing in 2006. The basis for the establishment of pharmacist prescribing in the UK was to improve patients' access to medicines and better utilise the expertise of health professionals. Supplementary prescribers implement a clinical management plan for patients in agreement with a prescriber, while independent prescribers make an initial assessment of patients and make decisions about their clinical management including prescribing.

In Australia there has been a move towards allied health professionals prescribing within their professional competence. For example, nurse practitioners have started prescribing, and podiatrists and optometrists have been granted limited prescribing rights. Remote area nurses have had a long history of supplementary prescribing and are progressing to independent prescribing. There have been preliminary studies on the attitudes of Australian pharmacists to expanded prescribing and possible models that could improve patient access to medicines.²⁻⁴

We recently completed a national survey of Australian pharmacists' views on expanding their prescribing role.⁵ Respondents represented all areas of pharmacy practice and gave their views in the absence of extended pharmacist prescribing.⁵ Respondents strongly favoured supplementary prescribing and noted that an expanded prescribing role would better use their skills and ease the workload on general practitioners.⁵ Around 30% of respondents supported the introduction of supplementary and independent prescribing and a minority supported an independent prescribing model.⁵

Most respondents identified that to assume expanded prescribing roles, additional skills in disease diagnosis and patient assessment would be required.⁵ In the UK, prior to undertaking the mandatory education and training for prescribing roles, pharmacists are required to have at least two years of post-registration patient-related experience. The training consists of 26 days of university-based study followed by at least 12 days of supervised practical experience with a designated medical practitioner. Weeks et al.⁶ in this issue describe their experiences with such a course and is useful background as courses will need to be developed to provide the necessary competencies for Australian pharmacists to move into expanded prescribing roles. The strong grassroots support from the profession for such a move, identified in our survey, gives the professional bodies a sound basis to lobby government and position the profession accordingly.⁵

The strong support for supplementary prescribing could indicate that pharmacists would like to progress to an expanded prescribing role in a stepwise manner. This is a sound approach as it will allow the development of necessary competencies in a suitable environment. Inevitably tension between supplementary and independent prescribing roles could become an issue. It is hoped the latter model would be the ultimate objective of an expansion of our professional roles.

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Can Pharmacists Afford not to Champion Medication Safety?

The Institute of Medicine has identified medication safety as one of the key issues that must be addressed to reduce medication errors.¹ Given that pharmacists are medication experts, it is not only a professional but a moral and ethical duty for pharmacists to take ownership and leadership for medication safety.

Medication safety

Safety is the foundation on which quality is built. Medication safety, therefore, must be an integral component of the entire medication management and use process, i.e. from procurement, distribution, to use and monitoring. At every step, pharmacists must pay attention to the risks identified, undertake a risk assessment and implement risk mitigation, if needed. Only then can we reduce preventable adverse drug events, medication errors and patient harm.

Rinehart² has surmised that conundrums will continue to occur as health care evolves and that pharmacists must take leadership in the management and resolution of medication safety conundrums to maintain a culture of safety and avoid patient harm.

The majority of medication safety conundrums encountered by pharmacists are due but not limited to misunderstanding, miscommunication or non-communication, and system and process failures. A safety culture that is open, transparent, supportive and committed to learning will lead to effective error and risk management at individual and organisational levels and should be encouraged.

Exploring error incidence in the medication use process (i.e. prescribing, transcription, dispensing and drug administration) on the wards, Leape et al.³ and Bates⁴ reported that prescribing (Leape 39%, Bates 49%) and drug administration (Leape 38%, Bates 26%) accounted for the majority of errors with transcription (Leape 12%, Bates 11%) and dispensing (Leape 11%, Bates 14%) coming in last. Computerised Prescriber Order Entry and pharmacist interventions during prescribing and drug administration are crucial and has the most impact in reducing errors. As for transcription and dispensing, use of information technology, automation and process re-engineering are recommended. These are examples of how pharmacists can focus on key medication safety issues and tackle them systematically and effectively.

Advantages

Pharmacists involvement and leadership in medication safety gives them the opportunity to fix what is wrong. For example, pharmacists can improve facilities, staffing levels, streamline processes, increase collaboration with doctors and nurses, and reduce waste. This would allow continuous improvement to take root, which would benefit staff, the department, organisation and ultimately the patient. The establishment of an institutional medication safety committee that is championed by a medication safety officer who is a pharmacist is a viable way of doing so. The medication safety committee can advocate collection of medication error data, perform analysis using established tools like root-cause analysis and make relevant recommendations to improve safety.

Disadvantages

On the flip side, the medication safety agenda can mean more accountability, more bureaucracy, more work, and can expose the profession's weaknesses. Medication safety can often be expensive because of improvements to facilities, equipment and implementation of technology. Medication safety can also increase resistance from the 'nay sayers' and those who do not want to change.

Cost

The cost of adverse drug events, medication errors and patient harm has been enumerated in numerous reports/studies and runs into billions of dollars annually.^{1,5} This is notwithstanding the mental, emotional and personal suffering that affects patients and their families and pharmacists and their families. This enormous social cost to the community is relevant and important.



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