The Pharmacy Guild of Australia

Submission to the Senate Inquiry on Palliative Care in Australia

March 2012

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1. Introduction

The Pharmacy Guild of Australia (the Guild) is the national peak pharmacy organisation representing community pharmacy. It strives to promote, maintain and support community pharmacies as the most appropriate primary providers of health care to the community through optimum therapeutic use of medicines, medicines management and related services.

The Guild welcomes the opportunity to provide a response to the Senate Inquiry on the provision of palliative care in Australia, and supports the National Palliative Care Strategy[1] and the National Pain Strategy[2]. The Guild has responded only to those aspects of the Terms of Reference where we believe community pharmacy should be engaged to further achieve accessible and coordinated palliative care for Australians.

This submission outlines the current role of community pharmacy in working with people requiring palliative care and their families/carers to remain living independently in the *community.* The submission further explores how the role of community pharmacy can be expanded and utilised in these settings to improve coordination and delivery of comprehensive palliative healthcare for Australians.

2. Summary of Key Issues

The following is a summary of the key issues identified by the Guild within this submission:

1. **Regarding the multidisciplinary team –**
    a. there needs to be a recognition of the potential role of a community pharmacist within a multidisciplinary team to assist patients requiring palliative care to remain in the home and receive the best care possible;
    b. consideration should be given to funding a community pharmacist's involvement in structured Care Plan arrangements for palliative care patients, for example, during case conferencing;
    c. any education strategy developed for health professionals should include the role of the community pharmacist as medicines management specialists; and
    d. members of the palliative care team require improved education regarding palliative care medicines that are listed on the Pharmaceutical Benefits Scheme (PBS).

2. **Regarding Controlled Drugs –**
    a. access to effective palliative care medicines requires more consistent legislation between states and territories to ensure access is not hampered;
    b. improved training of GPs and pharmacists regarding the legislative requirements for prescribing and dispensing Controlled Drugs[3] is required;
    c. improved communication between health care providers and state/territory drug branches needs to be facilitated;

[1] The National Palliative Care Strategy http://www.health.gov.au/internet/main/publishing.nsf/Content/palliativecare-strategy.htm

[2] The National Pain Strategy http://www.painaustralia.org.au/the-national-pain-strategy/national-pain-strategy.html

[3] Medicines listed in Schedule 8 of the Standard for the Uniform scheduling of Medicines and Poisons (SUSMP); http://www.tga.gov.au/industry/scheduling-poisons-standard.htm

d. relevant agencies should consider how to minimise cross-border barriers and streamline access to essential medicines for palliative care patients; and
e. a return system to is needed to assist in removing high-risk medicines such as Controlled Drugs and cytotoxics from households when they are no longer required.

3. **Regarding Quality Use of Medicines –**
    a. there would be significant benefits to the Government and to the patients and their families to fund Dose Administration Aids (DAAs) services as part of palliative care services along the lines of the Department of Veterans' Affairs (DVA) DAA funding;
    b. all persons receiving palliative care should be provided with information on Home Medicines Review (HMR) and how to request one from a GP;
    c. it is essential to ensure continuity of care as palliative care patients transfer between health care settings such as on discharge from hospital to home, residential facility or another hospital; and
    d. funding should be considered in Australia, where a hospice or other appropriate facility is able to identify the need for QUM services regarding palliative care and pain management by a community pharmacist, similar to that provided in the UK by the National Health Service.

4. **Regarding the registration and listing of medicines –**
    a. medicines that are not specifically registered on the Australian Register of Therapeutic Goods (ARTG) for palliation but registered for other use and indications should be identified, and sponsors of these medicines should be encouraged to register the medicines on the ARTG and the PBS list for palliative care;
    b. dual listing of medicines used in palliative care should be made possible; and
    c. organisations such as the Cancer Council Australia or Palliative Care Australia should be encouraged to make application for listing in the best interest of patients requiring palliative care treatment in the community.

3. An overview of the role of community pharmacy

Approximately 70 to 80% of patients receive palliative care in the home setting[4]. **Community pharmacists are cognisant of the special needs of those receiving palliative care and the need to provide and facilitate support services and longer-term strategies, to assist in providing such care within the home for as long as possible before needing to move to specialised facilities.**

Community pharmacists are the health professional most likely to come into regular contact with people in need of palliative care, and will have ongoing communication with their carers, doctors and therapists while they are receiving palliative care in the community. Quality of care is enhanced when patients are able to be treated by a team that comprises a variety of health professionals, each with their own set of knowledge, skills and experience.

[4] Hussainy SY et al (2011) 'Piloting the role of a pharmacist in a community palliative care multidisciplinary team: an Australian experience' *BMC Palliative Care* 10:16

Community pharmacy offers a highly accessible network of primary health care professionals providing quality advice and service. Community pharmacies exist in well spread out and accessible locations and often operate over extended hours seven days a week in urban, rural and remote areas. There are over 5,000 community pharmacies in Australia and on average, there are more than 14 visits to a community pharmacy per year for each man, woman and child in Australia, across metropolitan, rural and remote community settings[5].

The Guild believes the community pharmacist can undertake the following roles within a multidisciplinary team to assist patients requiring palliative care to remain in the home and receive the best care possible:

- **Provision of medicine management support services such as HMRs;**
- **Identifying and addressing common adverse effects of palliative care medicines, such as nausea, vomiting and constipation;**
- **Provision of aids and equipment to enable people to live safely in their own homes rather than needing institutional care, such as oxygen concentrators;**
- **Provision of home delivery service of prescription medicines and other pharmacy products to patients in the community who are not able to physically attend pharmacy to pick up their medicines;**
- **Provision of dose administration aids (DAAs) to facilitate better management of medicines;**
- **Provision of compounded medicines to address individual problems that patients may have with manufactured medicines such as swallowing difficulties or allergies to excipients;**
- **Provision of modern wound care treatment;**
- **Provision of medicine profiles to consumers who are confused about their medicines to assist them to better identify and understand what their medicines are for and how to take them;**
- **Facilitating the transfer of information about medicines between care providers to ensure continuity of patient care;**
- **Provision of locally relevant information on other health care services and resources; and**
- **Provision of medicines information for other members of the palliative care team, for example, off-label medicines.**

4. Quality Use of Medicines

Quality Use of Medicines (QUM)[6] is one of the four pillars of Australia's National Medicines Policy, and is defined as:

- selecting management options wisely;

[5] Guild Digest (2011)

[6] National Prescribing Service: About Quality Use of Medicines (www.nps.org.au)

- choosing suitable medicines, if a medicine is considered necessary; and
- using medicines safely and effectively.

Medicines are an essential component of care for those receiving palliative care, many of which will be on complicated medicine regimens that often have high level side effects and potential interactions with other medicines, or are pain management medicines which are highly regulated by state and territory legislation.

The following medicine management services which support QUM are provided by community pharmacists in the community and residential settings to reduce the number of adverse events experienced by assisting patients and their carers to better manage their medicines.

Home Medicines Reviews (HMR)

The HMR is a consumer-focused, structured and collaborative health care service provided in the *community setting*, to optimise quality use of medicines and consumer understanding. Community pharmacists work in consultation with GPs and other relevant members of the health care team to provide HMRs for people with complex needs within the community setting. A HMR is initiated by a GP with a referral to the accredited pharmacist, who conducts the HMR on behalf of the patient's community pharmacy. The accredited pharmacist attends the patient's residence and prepares a report based on the medicines and associated habits of the patient. The subsequent report is provided to the referring GP, who then discusses any recommendations with the patient and may make appropriate changes to their medicines management. The HMR service helps avoid or identify and address medicine-related problems and optimises medicine use. It is particularly useful for people who are on multiple medicines, confused about their medicines, see multiple practitioners or are regularly in and out of hospital.

Residential Medication Management Review (RMMR) Services

Medicine management reviews conducted in Residential Aged Care Facilities are called Residential Medication Management Reviews (RMMR). An accredited pharmacist conducts an RMMR in association with appropriate members of the eligible resident's health care team to identify, resolve and prevent medicine-related problems. Similar to the HMR, the RMMR involves collation of information about the resident's medicines and undertaking a comprehensive assessment. In addition to reviewing the resident's medicines, pharmacists support the facility by informing and training the nursing staff on the best way to store and administer the medicines and to manage medicine related issues.

Medicines Use Review (MUR)

MURs are known as a MedsCheck, and are being piloted under the Fifth Community Pharmacy Agreement. MedsCheck is an in-pharmacy service where a pharmacist checks a patient's medicines with the specific objective of improving patient outcomes by helping them to understand what their medicines are for and how to take them. The pharmacist can also assist the patient to address any identified medicine related issues. Under the pilot, the service is targeted to those patients who are currently taking five or more prescription medicines and/or have a recent significant medical event.

Dose Administration Aids (DAAs)

DAAs are weekly blister packs or sachets containing patients' medicines that are organised in line with their daily dosage schedule.

Community Setting: DAAs are designed to support at-risk patients (and/ or their carers) in the community to better manage their medicine, with the objective of improving adherence and avoiding medicine misadventure and associated hospitalisation. DAA's also provide the pharmacist and prescriber with a true indicator of compliance, which decreases the risk of misadventure by over or under use. This service particularly assists people who are confused by their medicines or who regularly mix them up or forget to take them. They are also useful to people who have difficulty opening or reading tablet bottles or other packaging. This should improve their quality of life and provide greater confidence and ability to remain living in their own home.

DAA services however are labour intensive, requiring significant professional input from the pharmacist. Community pharmacies have long been absorbing the costs in providing DAA services to their patients, mostly because of their professional and community responsibility.

In 2008, the Department of Veterans' Affairs (DVA) introduced a subsidised DAA service for eligible veterans in which the community pharmacist receives weekly payment for the DAA service and payment to review the service every 6 months to ensure it remains appropriate. This service builds on DVA's Quality Use of Medicines programs which include the Veterans' Medicines Advice and Therapeutics Education Services and aims to assist the veteran community to get the most out of their medicines and to reduce medicine mismanagement. Ongoing coordinated care is provided by the GP and pharmacist.

Residential Aged Care Setting: Many community pharmacies provide DAAs as part of their contracts with residential aged care facilities. The use of DAAs in the supply of medicines to aged care facilities reduces the rate of error in medicine administration and improves the QUM and in-turn allows the nursing staff additional time to provide quality care to patients.

5. Addressing the Terms of Reference

(a) The factors influencing access to and choice of appropriate palliative care that meets the needs of the population

As palliative care is aimed at offering the highest possible level of comfort to the patient during the final phase of his/her life, appropriate treatment should be easily accessible and supported to allow the patient to lead as normal a life as possible. Home treatment is very often possible, and is often the patient's preference. Patients wishing to stay with their families for as long as possible should be encouraged to do so, and the community pharmacist, along with all other health professionals, can support the patient, and family members to do so.

It is important to note that not all people approaching the end of life require specialist palliative care in a residential or acute care setting. Community pharmacy is the most accessible health service in Australia and with many located in areas with limited health service providers. Community pharmacy can be utilised to optimise equity of access to non-specialist palliative care support, including to people living in rural and regional areas, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, those with disabilities, and children and adolescents. For example, the network of over 5000 community pharmacies includes remote locations such as Winton, Thursday Island or Nhulunbuy in rural and regional Australia.

The Guild believes that Australia's regulatory, health care and social services systems all pose barriers to effective palliative care and pain relief in the form of practical constraints. The lack of transportation to the physician and the lack of a home caregiver to assist with administering medicines pose major obstacles to treatment. Pharmacists providing domiciliary pharmaceutical care can effectively overcome these barriers and as a result improve the quality of life for the patient. Community pharmacists delivering 'in home' care to patients need to have access to supplies of the necessary medicines for each patient, where delays in obtaining appropriate medicines may lead to unnecessary decline in the patient's condition.

Palliative care patients usually require large quantities of opioids for effective pain control, sometimes over lengthy periods of time. Because of the high risk of abuse and misuse with opioids, they are categorised as Controlled Drugs and are strictly regulated by state and territory Health Departments. Unfortunately, these controls can hinder access to these medicines by legitimate patients such as palliative care patients who are also dealing with considerable psychological issues. While the issue of prescribers needing to be registered within a particular jurisdiction to prescribe opioids has been largely addressed with the National Registration and Accreditation Scheme for health practitioners, the regulatory discrepancies between jurisdictions can still be problematic, particularly for communities on state or territory borders where patients may travel across jurisdictions. For example:

- prescriptions for Controlled Drugs in NSW must have the prescribed quantity written in words and figures[7], however this is not a requirement in the ACT. Should a palliative care patient present a prescription from an ACT doctor or specialist for a Controlled Drug to their regular pharmacy in Queanbeyan (NSW), the prescription cannot be dispensed if the prescription is not written correctly and the patient would need to attend an ACT pharmacy or have the prescription re-written.

- prescriptions for Controlled Drugs in Queensland require the patient's date-of-birth to be included[8] whereas this is not required in NSW. A patient attending a doctor in Tweed Heads could not have their prescription dispensed if presenting to a pharmacy across the border unless the doctor has included the date-of-birth.

Similar issues exist with requirements for special approvals for long-term use of Controlled Drugs in some jurisdictions and not in others. Health care professionals in these areas are often not aware of the discrepancies or confused by the different jurisdictional requirements.

The Electronic Recording and Reporting of Controlled Drugs (ERRCD) initiative, funded by the Australian Government for implementation under the Fifth Community Pharmacy Agreement may be of value in addressing these issues by improving communication between prescribers, community pharmacists and state/territory Health Departments to better manage the use of Controlled Drugs.

The Guild believes that relevant agencies such as the National Coordinating Committee on Therapeutic Goods (NCCTG) and the Australian Health Ministers' Conference should consider how

[7] Refer to s.80(1)(f) of the Poisons and Therapeutic Goods Regulation 2008 (NSW)

[8] Refer to s.79(4)(c) of the Health (Drugs and Poisons) Regulations 1996 (QLD)

to minimise cross-border barriers and streamline access to essential medicines for palliative care patients. This is best supported by community pharmacist involvement on the support team to advise about jurisdictional legislative issues in the supply and use of palliative care medicines.

(b) The funding arrangements for palliative care provision, including the manner in which sub-acute funding is provided and spent

Consideration should be given to funding a community pharmacist's involvement in structured Care Plan arrangement for palliative care patients. Further, the Guild believes that there would be significant benefits to the Government and to the patients and their families to fund DAA services as part of palliative care services along the lines of the DVA DAA funding. This would provide a greater capacity for the patients to remain living in their own home and would also result in reduced hospitalisation and better quality of life and security of mind for the patients and their families. The provision of DAAs would also limit the amount of uncontrolled narcotic analgesics that are kept in the patient's home, reducing the risk of palliative care patients being a target for theft.

Further, many pharmacists specialise in compounding medicines to meet individual patient needs to resolve problems patients may have with standard manufactured medicines, such as swallowing difficulties or allergies to excipients such as gluten, fillers or dyes. Compounded medicine may also be useful in situations when prescribers want a different strength of a medicine to that which is available 'off-the-shelf'. Only a limited amount of compounded medicines are subsidised on the PBS and very little is applicable to palliative care, meaning specialised compounded medicines may be unaffordable for palliative care patients, particularly concessional patients. **The Guild supports subsidising compounded medicines to assist in meeting the needs of individual palliative care patients**.

(c) The efficient use of palliative, health and aged care resources

The Guild believes that the cost benefits of community pharmacist involvement in palliative care would result in moderate to high cost savings. An Australian study extrapolated that community pharmacists who proactively assessed their clients' drug management at point of purchase could save Australian health care approximately $15 million dollars annually, primarily through interventions such as correcting doses, the provision of prescribing information and interventions to circumvent medicine interactions[9].

(d) The effectiveness of a range of palliative care arrangements, including hospital care, residential or community care and aged care facilities

Continuity of care is essential as palliative care patient's transfer between health care settings. There must be effective communication between the acute care and palliative care sectors on admission to and discharge from hospital as it is essential that all members of the palliative care support team, including community pharmacists, are aware of any issues with or changes to a patient's medicine regimen in a timely manner. The need to ensure regular communication is especially required on discharge from hospital to home, hospice, residential facility or another hospital. The GP and community pharmacist must be aware of what medicines the patient is using or

[9] S.I. Benrimoj et al 'Economic impact of increased clinical intervention rates in community pharmacy: a randomised trial of the effect of education and a professional allowance' (2000) *Pharmacoeconomics*. Vol.18(459-68).

may require in the short-term future. Some of the medicines used with palliative care patients may not be routinely kept in stock at the local community pharmacy. By informing the community pharmacist of the patient's needs, they can ensure adequate supplies are on hand. Community pharmacists who prepare DAA packs for their palliative care patients also need to know the patient's current medicine regimen to ensure the DAA is packed correctly.

This issue has been highlighted by the Australian Commission on Safety and Quality in Health Care (ACSQHC) via the National Medication Management Plan, emphasising the importance of medication reconciliation, which has been shown to reduce errors and adverse events associated with poor quality information at transfer of care and inaccurate documentation of medication histories[10]. Medication reconciliation is a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines, which can be assisted by the service provided via community pharmacy as outlined above.

In the UK the National Health Service funds hospices to enable the purchase of pharmaceutical advice and support from pharmacists, with a recent report highlighting the 'important role that pharmacists play in palliative care', further recommending that pharmacy services continue to be fully funded[11]. The advice provided by the community pharmacist includes individual patient prescription monitoring, recommendations for formularies, discharge planning, and the safe storage, administration and disposal of medicines[12]. **The Guild believes such funding should be considered in Australia, where a hospice or other appropriate facility is able to identify the need for QUM services regarding palliative care and pain management by a community pharmacist.**

(e) The composition of the palliative care workforce

Effective palliative care requires inter-professional collaboration. The increasing need for palliative care in the community and patient preference for death at home is well documented. On average, terminally-ill patients will spend 90 per cent of their final year at home, under the care of the family doctor and primary health care team. More than half of patients with a terminal illness express the wish to remain at home as long as possible and, if possible, to die there.[13]

As the most accessible health care professional for patients, their carers and families, the community pharmacist should be an integral member of all interdisciplinary palliative care teams, as good palliative care depends enormously on teamwork and effective symptom control. The Guild recommends that any education strategy developed for health professionals should include the role of the community pharmacist.

Most of the patients in need of palliative care and their carers already have a long trusted relationship with their regular community pharmacist. In the difficult circumstances of palliative care, this relationship becomes even stronger. Pharmacists are aware of the valuable contribution they can make, particularly in medicines management; and a research project undertaken in 2005[14]

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[10] Australian Commission on Safety and Quality Health Care 'Assuring Medication Accuracy at Transitions of Care: Medication Reconciliation' webpage [last updated 11 November 2011]

[11] T. Hughes-Hallett et al (2011) 'Palliative Care Funding review: Finding the right care and support for everyone' final report for the National Health Service (UK)

[12] 'The role of pharmacists in palliative care' (2002) EuroPharm Forum

[13] M. Jiwa et al 'The role of the Pharmacist in the Provision of Palliative Care Final Report' (2007) Curtin University of Technology for The Pharmacy Guild of Australia Fourth Community Pharmacy Agreement Research & Development Program

[14] R.L Nation et al 'Improving Medication Management of Palliative Care Patients: Enhancing the Role of Community Pharmacists Project' (2005) Monash University for the Pharmacy Guild of Australia Third Community Pharmacy Agreement Research & Development Program

revealed patients and their carers supported the role of the community pharmacist in the palliative care cancer team, however, they were not fully aware of their role in providing information and advice regarding medicines. As such, **the Guild recommends that part of any education strategy to patients and their carers should include the role of community pharmacists in providing information and support to improve medicine management. Further, there needs to be improved education for all health care professionals involved in palliative care. Prescribers and pharmacists need to be aware of the palliative care medicines that are listed on the PBS as well as recommended prescribing practices for palliative care patients, such as prescribing laxatives concurrently with opioid analgesics to reduce the risk of constipation[15].**

A lack of knowledge regarding palliative care is a major barrier to community pharmacist involvement into palliative care provision. The community pharmacists that participated in the 'Improving Medication Management of Palliative Care Patients: Enhancing the Role of Community Pharmacists Project' which delivered online training believed that after training they were better able to respond to palliative cancer care related queries, assist in the management of symptoms such as pain, nausea, constipation and mucositis, and work in collaboration with medical professionals that prescribed opioids[16].

The following is a brief outline of a number of examples where community pharmacy can provide both traditional and expanded pharmacist activities, including a variety of clinical, educational and support roles:

- Provision of effective medicines for symptom control and pain management

The primary role for community pharmacists in palliative care is the safe, efficient and timely provision of medicines and to provide advice for patients, carers and other members of the health care team. The right choice of medicine, its dosage, the detection of side effects, interactions, over- or under-utilisation (particularly in the case of polypharmacy, as is often the case with palliative care) are key points where communication between prescribers, patients/carers and pharmacists are of high importance. In addition, community pharmacists can advise other members of the health care team about the regulatory requirements in prescribing, storing, using or discarding highly regulated medicines such as opioids for pain control.

Community pharmacists can also help identify the best pharmaco-therapeutic solution for pain and symptom control from both a clinical and a financial point of view. Community pharmacists can improve the cost effectiveness of pharmacotherapy by monitoring patients' response to medicines and recommending alternatives when appropriate, minimising duplicative and interacting medicines, improving storage and transportation, and educating patients, families, carers and other members of the health care team about the most efficient ways of handling and using medicines. For patients in the last stage of life, aiming to maximise comfort should mean rationalising and optimising their medicine regimen as much as possible and the community pharmacist can assist in identifying the most appropriate pharmacotherapy solution, in terms of cost and effectiveness including specific products/devices and preparations needed in palliative care.

[15] PJ Ravenscroft; Opioids – clinical applications in palliative care; Australian Prescriber 1996; 19:66-8

[16] Op cit

- Provision of extemporaneous compounding of non-standard dosage forms

Pharmacists can also assist in the formulation and preparation of medicines for people who cannot use standard manufactured medicines because of issues such as swallowing difficulties, allergies to excipients such as dyes, fillers or gluten, or adjusting the concentration of active ingredients.

- Medicines history/documentation

The pharmacist has a computerised record of the full history of the medicines previously dispensed in his/her community pharmacy for use by the patient. Patients often move between care settings such as hospital, hospice and their own home and accurate records of the patient's medicines should be transferred between these settings. Pharmacists maintain patients' medicines profiles and monitor all prescription and non-prescription medicines use in terms of their safety and effectiveness.

- Assisting with compliance

Advice from community pharmacists to patients and carers about medicine dosage, administration and anticipated side effects can aid compliance. Pharmacists seek to ensure that all patients and families/carers understand and follow the labelling directions provided with medicines and provide devices and equipment to assist with accurate measurement of liquid dosage forms. Pharmacists advise patients about the role and potential toxicity of alternative and complementary therapies. Pharmacists can visit patients' homes to communicate directly with patients and carers and to make necessary assessments. To assist with a safe self-administration of medicines, pharmacists can provide and, where necessary, provide compliance aids such DAAs.

- Identification of distress

Community pharmacists have regular contact with patients and their carers and are often aware of the early signs of distress. Distress presents itself in palliative care patients as a continuum: from mild distress to severe forms that may then lead to depression, anxiety, and crisis[17]. This may result in more frequent visits to their medical specialist, GP and emergency room, poor decision making by the patient, refusal or interruption of treatment, and dissatisfaction with traditional care. As part of the healthcare team, community pharmacists will be in a position to provide screening and monitoring of distress and if necessary, referral can be made to appropriate health professionals.

- Safe disposal of all medicines after death

Pharmacists are able to assist families with the removal of the medicines remaining in patients' homes using the Return of Unwanted Medicines (RUM) Scheme[18]. However, the RUM system precludes the collection of some medicines such as liquid cytotoxic medicines and there can be jurisdictional restrictions on the disposal of Controlled Drugs. As such, **establishing a return system for these medicines should be considered.**

[17] 'Clinical practice guidelines for the psychological care of adults with cancer' (2003) National Health and Medical Research Council
[18] http://www.returnmed.com.au/

(f) The adequacy of standards that apply to the provision of palliative care and the application of the Standards for Providing Quality Care to All Australians

The Guild supports the Standards developed by Palliative Care Australia to represent a whole-of-sector approach, ensuring high quality, needs- based care at the end of life, with an emphasis on the relationship between primary care providers and specialist palliative care services. Specifically, the Guild acknowledges inclusion of pharmacists as part of the definition of the interdisciplinary team[19].

(g) Advance care planning

In 2004, several medicines used in palliative care were listed on the PBS. These medicines were previously only available freely through acute care settings or at a non-subsidised rate for people in the wider community. The Guild acknowledges that this now provides some access to medicines at an affordable price for people who wish to remain in the community during the terminal phase of their life and will help ensure that quality of life is maintained through appropriate pain management and symptom relief.

However, **the Guild is concerned that the preparations which may be prescribed for patients receiving palliative care currently listed on the PBS is not adequate and needs refinement for the following reasons:**

There are medicines that are not specifically registered on the Australian Register of Therapeutic Goods (ARTG) for palliation but registered for other use and indications. For example, ketamine, a medicine commonly used in palliative medicine is only registered as an anaesthetic agent for diagnostic and surgical procedures that do not require skeletal muscle relaxation[20]. Such anomalies should be rectified by sponsor encouragement to register the medicines on the ARTG and the PBS list as was the case for methadone, with one company following this process which has led to a specific brand of methadone being registered for the use in the treatment of severe pain[21].

Dual listing of medicines used in palliative care should be made possible. For example, morphine oral solutions and morphine injections should be listed both in the general section and the palliative care section. The listing in the palliative care section should allow quantities and number of repeats appropriate for palliative care use including use in syringe drivers.

In addition, organisations such as the Cancer Council Australia or Palliative Care Australia should be encouraged to make application for such a listing in the best interest of patients requiring palliative care treatment in the community.

The Guild supports the notion that the misuse of pharmaceuticals such as opioids should be addressed in the national pharmaceutical misuse strategy under development, however, believes that it is essential that legitimate patients such as those receiving palliative care are not affected.

[19] 'Standards for providing Quality Palliative Care for all Australians' (2005) Palliative Care Australia
[20] 'KETALAR ketamine 200mg/2mL (as hydrochloride) injection vial' Public summary for ARTG entry
[21] 'SIGMA Methadone Syrup methadone hydrochloride 25mg/5mL oral liquid bottle' Public summary for ARTG entry

(h) The availability and funding of research, information and data about palliative care needs in Australia

The Guild is supportive of research opportunities to assist in the available data and evidence to improve future palliative care arrangements and believes that any research into team-based care should involve community pharmacy for all of the reasons outlined in this submission.

Regarding the Personally Controlled E-Health Record (PCEHR), the Guild welcomes the PCEHR as an integral component of Australia's future health infrastructure. The PCEHR has the potential to improve care and support to the palliative care patient, however, the Guild is concerned that the proposed 'opt-in' model due for release in July 2012 will not facilitate a health care provider's access to a complete medical history.

6. Conclusion

It is an enormous challenge for Government to provide adequate, efficient and quality palliative care services. Polypharmacy and the alarming rates of medicine related problems are crucial factors resulting in poor health outcomes, admission to hospital and reliance on hospices and other facilities, rather than remaining in the home.

Therefore, the Guild supports and recommends policies and systems that:

- sustain independence and quality of life;
- support people requiring palliative care to live independently in the community for as long as possible before needing to move to specialised facilities; and
- have the potential to reduce admissions to hospital and poor health outcomes due to medicine management issues.

Community pharmacists can make valuable contributions in the provision of palliative care to terminally ill patients by assisting in appropriate pain and symptom control. Many patients' medicine use may deviate from that prescribed, and they may also use complementary medicine, of which the prescriber may be unaware. Patients with chronic pain may be in need of a higher level of pharmaceutical management because of a greater difficulty to obtain pain relief or a lack of understanding of pain management and the greater potential for adverse effects and interactions between medicines. A palliative care patient's clinical outcome will benefit from management by a multidisciplinary primary care team involving a community pharmacist, where a recent study in the US reported that the majority of a pharmacist' recommendations were accepted by physicians, and most patients achieved improvement or resolution of the presenting symptom.

The Guild highlights the pharmacists' expert knowledge in medicines and medicines management and the current infrastructure and network of community pharmacy. In 2010, the Guild produced 'The Roadmap – The Strategic Direction for Community Pharmacy' which provides an analysis of where community pharmacy is today and a plan for its future direction (refer to http://www.guild.org.au). This includes a template of practical mechanisms through which community pharmacy can develop future services nationally relating to palliative care services, which has been attached for the Committees information (attachment 1).

Attachment 1

Community Pharmacy Roadmap Program Development Template

Program/Service Quadrant	**Palliative Care Services** **C – In-pharmacy health services and programs**
1. Program/Service Description	
a) Background	Palliative care is predominantly home based care and is often multi-disciplinary[22], requiring input from GPs, specialists, allied health workers and palliative care workers. It can also involve multiple sites of care, including hospital inpatient and outpatient facilities as well as hospice care. Many medicines used in palliative care are available through the Pharmaceutical Benefits Scheme (PBS) and poly-pharmacy is commonly required. Palliative care will sometimes necessitate the use of exceptional doses; use of medication outside registered indications; and use of non registered medicines[1]. A Third Community Pharmacy Agreement (3CPA)[23] project focused on the identification of education needs of community pharmacists in palliative cancer care. The project identified a number of impediments to community pharmacist involvement and integration of community pharmacy practice into palliative cancer care service provision. These included: • a lack of education/knowledge regarding palliative cancer care by the majority of community pharmacists; • lack of remuneration for service provision; • infrequency of palliative care patients/carers visits to community pharmacies; and • workforce patterns of community pharmacists. A subsequent Fourth Community Pharmacy Agreement (4CPA)[24] project looked to specifically promote the alignment of community pharmacy with the National Palliative Care Strategy[25]. Key findings included: • active engagement of community pharmacists in palliative care, including the provision of advice to patients and their carers; • a number of barriers to stocking medicines used in palliative care; and • the Palliative Care Medication Management review (PCMMR) feasibility trial demonstrated that the role of pharmacy could be extended. A Victorian-based project revealed that the inclusion of a pharmacist into a community palliative care service team[26]: • increased the knowledge of team members of medications used in palliative care and their management; • improved knowledge of potential problems with medications and how to manage them; • led to a change of practice for the benefit of patients ; • enabled ongoing education and support from the pharmacist to the team members; • allowed for inservice education to be provided;

[22] *Therapeutic Guildlines: Palliative Care* (version 3) (2010)

[23] 'Improving medication management of palliative care patients' (2005) 3CPA Research & Development Program.

[24] 'The role of the pharmacist in the provision of palliative care' (2010) 4CPA Research & Development Program

[25] *National Palliative Care Strategy – A national framework for palliative care service development* (October 2000) Commonwealth Department of Health and Aged Care

[26] 'Pharmacist in community palliative care multidisciplinary team pilot project final report' (2010), Department of Health, Victoria. Produced for the *Palliative Care for People at Home Initiative*.

	• assisted in improving contacts with the GP and palliative care service for the benefit of the patient and family; and • assisted the patient and family to better understand the medications. Further, the report states the inclusion of a pharmacist could also lead to: • a reduction in medication error by both health professionals and patients/families; • an increase in medication concordance; • reduced hospital admissions due to medication errors; and • an increase in confidence by patients/families in the use of medications.
b) Brief Description	A palliative care program for community pharmacists to deliver enhanced palliative care services would have two distinct elements; an educational component to increase the knowledge, understanding and beliefs of community pharmacists about palliative care, and the participation of specially trained community pharmacists as part of a multidisciplinary team through a Palliative Care Medication Management Review service. Within this framework, community pharmacists would be an integral member of the multi-disciplinary team providing care to palliative patients. In addition to dispensing medicines and related services within pharmacies, they would provide medication management services most appropriate for the patient. This would include the provision of patient-specific pharmacy services such as the monitoring of drug interactions and adverse events; review of drug product selection including appropriate dosage forms; compounding medications extemporaneously when required; improving drug storage and transportation; and educating staff, patients and families about the most efficient and effective methods of storing, handling and using medications.
c) Alignment with Government Policy	The service would support the Commonwealth Government's National Palliative Care Strategy by improving community and professional involvement in palliative care services, improved quality and effectiveness of palliative care service delivery and support partnerships in the provision of palliative care across all settings[4]. Further, the National Hospital and Health Reform Commission report identified increased funding for sub-acute care facilities including palliative care[27].
d) Expected Outcomes for Government and Community Pharmacy	For a government perspective, the provision of palliative care services through community pharmacy would improve the cost-effectiveness of pharmacotherapy in palliative care leading to improved health outcomes and budgetary savings. From a pharmacy perspective, there will be a greater recognition of the role of community pharmacists as members of the primary health care team. Community pharmacy will have the opportunity to develop a viable business involving service provision as an adjunct to product supply and will have a greater capacity to effectively utilise the increased number of pharmacy graduates in a manner that benefits both pharmacy practice and the community. Pharmacy graduates will continue to have a positive outlook for community pharmacy as a career, supporting the viability of pharmacy education providers.
e) Consumer Benefits	Medication regimes for patients in the last stages of life should be optimised for maximum patient comfort[1,4]. Patients and carers would benefit from the integration of community pharmacy into palliative care services as the pharmacist can help identify the best pharmacotherapy solution in terms of effectiveness, including specific products, devices and services needed in palliative care, as well as monitor drug interactions and adverse events. Advice from pharmacists regarding a variety of issues including dosage, mode of administration and anticipated side effects would aid compliance and increase confidence of patients and carers.

[27] 'A healthier future for all Australians – Final Report of the National Health and Hospitals reform Commission' (June 2009)

	The accessibility of pharmacists through the 5,000-fold network of community pharmacies throughout Australia allows for extensive integration at minimal cost. The overall community stands to benefit by having the pharmacist as an integral member of multidisciplinary palliative care teams. Many patients in need of palliative care, and their carers, would already have a long and trusted relationship with their regular community pharmacist.
f) Who Performs the Service	• Pharmacists • Members of the palliative care multidisciplinary team
g) Collaboration with Other Health Care Professionals	*Is the service likely to require any formal collaboration with other health care professionals?* Yes - In delivering palliative care services, pharmacists would work closely with GPs, specialists and palliative care nurses and other members of palliative care teams.
2. Implementation and Enablers	
a) Stakeholder Consultation	*Representative bodies from the following areas will need to be consulted in order to fully develop and implement a program:* • Consumer/advocacy/supporting organisations relating to palliative care • Pharmacy organisations • GP organisations • Trainers • Government bodies • Funders • Product sponsors • National Pharmacy Board • Pharmacy software vendors • Professional insurers • Other allied health professional bodies
b) IT Requirements	*Is pharmacy software required to deliver this program?* IT solutions will assist in the delivery of palliative care services. Program software should ideally be integrated with pharmacy software, streamlined for ease of use and consistent with pharmacy workflow.
c) Infrastructure and Staffing	*Is a private consultation area required to deliver this program?* Existing consultation areas are likely to suffice, with modifications where required to ensure sufficient customer privacy. *Is the program within the pharmacist's/pharmacy assistant's normal scope of practice?* Yes *Will an additional pharmacist be needed?* Individual pharmacies will need to assess their workload capacity and the extent of pharmacist consultation involved. There may be a need for another pharmacist to manage other professional activities within the pharmacy, such as the supply of Pharmacist Only Medicines.
d) Training	*What additional formal training is likely?* Pharmacy graduates should be trained to a level where they can confidently provide support services upon registration. Training for pharmacists and pharmacy assistants should include on-line training where possible to maximise participation. Refresher training should also be available for registered pharmacists so that services remain aligned with current guidelines. *Does any suitable training exist?* Yes - a number of programs designed to enhance the knowledge and skills of health professionals are available. Specific on-line educational materials have been developed for pharmacists through the 4CPA Research & Development project[3]. However, additional specific training for MMR-accredited community pharmacists would be required per the identified protocol.

e) Supporting Standards, Procedures and Templates / Checklists	*Will a QCPP standard be required?* Yes. *Will professional guidelines and/or standards be required?* Yes *Are there any national guidelines which need to be taken into account in developing the program to ensure consistency with best practice?* The following should be considered: • Palliative Care Australia - Standards for Providing Quality Palliative Care for all Australians (2005) • Therapeutic Guidelines - Palliative Care version 3 (2010) • The Society of Hospital Pharmacists of Australia - Standards of Practice for the Provision of Palliative Care Pharmacy Services (2006)
f) Legislation / Regulation Implications	It will be necessary to ensure all elements are aligned with relevant legislation.
3. Funding	
Funding Options	*Possible funding options include:* • Community Pharmacy Agreement • Alternative Commonwealth Program (e.g. National Palliative Care Strategy, Palliative Care for People at Home Initiative.) • State/Territory Health Departments *Has any funding for this Program been secured?* No.
4. Timelines	
Timelines	√ Established community pharmacy practice √ Immediate to short-term implementation (< 30 June 2015) – subsidised service √ Medium-term implementation(1 July 2015 to 30 June 2020) ☐ Longer-term implementation (> 1 July 2020)