

# Ensuring Quality Use of Medicines in Country Health SA

## Project Report

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Government  
of South Australia

SA Health

# DRAFT – FOR CONSULTATION

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# DRAFT – FOR CONSULTATION

## Executive Summary

Pharmacy services within hospitals are made up of two major components which are the traditional medication supply role and the provision of clinical pharmacy services. Optimising the safe and effective use of medicines (otherwise known as the Quality Use of Medicines) requires the provision of Clinical Pharmacy Services. This Quality Use of Medicines (QUM) has been demonstrated to improve outcomes including reduced re-admissions and adverse events. Achieving QUM was a key driver in the implementation of the Pharmaceutical Reform (the Reform) into the majority of metropolitan SA public hospitals where introduction of the Australian Pharmaceutical Advisory Council (APAC) *Guiding Principles to Achieve Continuity in Medication Management* was mandated.

In 2009 Country Health SA (CHSA) Executive recognised that prior to implementing the Reform across country hospitals it was necessary to conduct a fact-finding process to establish the quantity and quality of current pharmacy services. This project therefore had the following objectives:

- Evaluate the nature and extent of pharmacy service delivery to SA country hospitals
- Identify barriers to increasing quality use of medicines in country SA
- Make recommendations to improve pharmacy service delivery, with a particular emphasis on the quality use of medicines component of the Reform
- Evaluate the potential to introduce PBS to relevant country hospitals.

It was found that significant variability exists in the quantity and quality of pharmacy services provided to patients in country hospitals. Whilst Directors of Nursing (DON), pharmacy staff and other CHSA staff are committed to implementing the principles and practice of the quality use of medicines (QUM), for a range of reasons the current level of QUM related services in country hospitals is not consistent with those available in the major metropolitan hospitals. Country patients generally have lower access to services directed towards the safe and effective use of medicines, and it is recognised that this is associated with a potentially greater risk of medication related adverse outcomes. Most pharmacy services to CHSA hospitals currently do not have the capacity to meet the Australian Pharmacy Advisory Council (APAC) guidelines.

A framework for the development of a 'virtual' pharmacy service across CHSA is proposed to guide progress towards compliance with APAC, Equip and other relevant standards. This framework includes the strengthening of existing onsite pharmacy departments, the development of clinical leadership, attention to contracting to improve efficiency and quality of services through a focus on consistent key performance indicators and the development of consistent policies and procedures across country.

This development requires significant investment in infrastructure and resources in CHSA hospitals. Further work is required to identify funding sources to enable full implementation of the recommendations. It is realistic to consider a staged implementation over a five year period. It is recognised that increased staffing resources at those sites with pharmacy departments is critical to support the implementation of QUM both locally and across country and assist in addressing issues with staff retention and attraction at those locations.

Although this process will require additional funding, there are potential cost offsets identified through the introduction of PBS dispensing to those CHSA hospitals with a pharmacy department and other identified sources.

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## Summary of Recommendations

1. That consideration be given to a more uniform approach to the purchasing of medications
2. That systems be reviewed to ensure that patients transferred between hospitals have timely access to medications
3. That CHSA sites move to more consistent level of pharmacy service provision to meet health service needs.
4. That CHSA, in conjunction with the Strategic Procurement Unit, introduce consistent contracts for pharmacy services across CHSA and that these contracts be managed centrally. Further, that the positive relationships that have been established between country hospitals and local community pharmacists/contracted providers should be preserved where possible
5. That strategies to encourage the use of the National Inpatient Medication Chart (NIMC) across country SA hospitals be further developed
6. That pharmacy services to country hospitals move toward meeting APAC guidelines, in line with metropolitan hospitals which have adopted the Reform
7. That current CHSA pharmacy departments be further developed to increase clinical pharmacy capacity both locally and across country to meet QUM.
8. That clinical pharmacy services be introduced to Berri and Port Lincoln and further analysis regarding the appropriateness of an onsite pharmacy or other models be undertaken
9. That a pharmacy Clinical Lead role be introduced to CHSA
10. That the role, function and membership of the CHSA Drug and Therapeutics Committee be reviewed to strengthen it's ability to lead implementation of QUM including implementation of the NIMC
11. That the clinical lead position be charged with the responsibility to develop recruitment and retention strategies for country SA pharmacists.
12. That recruitment and retention strategies recognise the advantages of working in rural areas and build on these, while addressing professional isolation and other issues.
13. That specific, culturally appropriate services for Aboriginal people be further developed in collaboration with relevant stakeholders
14. That the findings of this project be considered in Cytotoxic Therapy reviews currently being conducted in SA
15. That where cytotoxics are to be delivered and administered in CHSA facilities the appropriate infrastructure and staffing that optimises quality and safety must be in place.
16. That an in depth cost/benefit analysis of introducing PBS and outpatient dispensing to individual Country Health SA pharmacy departments be undertaken

## 1. Background

Pharmacy services within hospitals are made up of two major components which are the traditional medication supply role and the provision of clinical pharmacy services. In essence the latter refers to the provision of services aimed at optimising the safe and effective use of medicines. This quality use of medicines has been demonstrated to improve patient outcomes including reduced readmissions and adverse outcomes<sup>1, 2</sup>. An Australian study conducted in 2003 found that for every dollar spent on clinical pharmacy services, \$23 was saved due to a reduced length of stay and likelihood of readmission<sup>3</sup>.

It was these positive outcomes that contributed to a decision by the Commonwealth Government to introduce the Pharmaceutical Reform process to public hospitals throughout Australia, which was aimed at improving clinical pharmacy services. The Health Ministers' Joint Communiqué of April 2004, stated that *'to help safer use of medicines, by the end of 2006, every hospital will have in place a process of pharmaceutical review of medication prescribing, dispensing, administration and documenting processes for the use of medicines'*

On the 4th December 2006, the South Australian Government accepted the Commonwealth offer to participate in the Reform process<sup>4</sup>, which comprised two key outcomes:

1. Access to the Pharmaceutical Benefits Scheme (PBS) for
  - Admitted public and private patients on discharge
  - Non-admitted patients, and
  - Day admitted patients for a range of cancer chemotherapy drugs.
2. Implementation of the Australian Pharmaceutical Advisory Council's (APAC) Guiding Principles to Achieve Continuity of Medication Management<sup>3</sup>.

The key objectives of the Reform are to improve:

- Equity of access to medication for patients regardless of their place of care - public hospital, private hospital or community sector.
- Safety and quality of medication management, including a smooth transition between hospital and community based care.

It was envisaged that the Reform would be introduced in South Australia public hospitals in two phases. The first phase would be introduction of the Reform in metropolitan hospitals and the second would be to country hospitals. This decision was made for a number of reasons including:

- Country Health South Australia has several pharmacy service models across a range of different sized hospitals, whereas metropolitan hospitals have a single model of in-hospital pharmacy services.
- The models in place in country SA were not well documented or widely understood.
- Country Health SA has a number of issues that are more pertinent to rural service delivery (for example, critical mass, local health service networks, attraction and retention of staff)

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<sup>1</sup> SHPA Standards of Practice for Clinical Pharmacy, Journal of Pharmacy Practice and Research, 2005

<sup>2</sup> Guiding Principles to achieve continuity in medication management, July 2005

<sup>3</sup> A prospective multicentre study of pharmacist initiated changes to drug therapy and patient management in acute care government funded hospitals, Dooley, Allen, Doecke et al, British Journal of Clinical Pharmacology, 2003

<sup>4</sup> Pharmaceutical Reforms Newsletter (Issue One, December 2006), South Australian Department of Health

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To date the Reform has been introduced in metropolitan South Australia at Flinders Medical Centre, Royal Adelaide Hospital, Women's & Children's Hospital, the Queen Elizabeth Hospital and Lyell McEwin Health Services. This process was led by the Pharmaceutical Services and Strategy Branch of SA Health and was facilitated by the funding of 77 additional clinical pharmacist positions. Currently no implementation has been planned for phase two.

### 2. Evidence supporting the Quality Use of Medicines (QUM)

The APAC *Guiding Principles to Achieve Continuity in Medication Management* (July 2005) provides evidence of the need for continuity of care including:

- On admission to hospital, up to one in two patients had an incomplete medicine list provided, resulting in a medicine not being administered during the hospital stay
- 1.6 per cent of hospital admissions were associated with the occurrence of an adverse medicines event, and medicines are considered to be the causal agent of 10 per cent of all adverse events experienced in hospitals
- 14.5 per cent of consumers were on four or more medicines
- 12 per cent of patients had an error in their discharge prescription

The introduction of the APAC guidelines in 1998 has been shown to have a positive impact on problems related to medicines, fewer visits to health care professionals, improvements in functional health status and a trend to reduced readmission rates.

Further, medication-related adverse events are the most frequently reported adverse events reported in hospitals. Examples as reported by Runciman et al<sup>5</sup> include:

- Omission of medication (27% of medication incidents)
- Overdose/dose too high (19%)
- Wrong medication administered (9.5%)
- Adverse drug reaction (1.5%)

### 3. Context

As a region, Country Health SA (CHSA) covers 99.8% of the land mass of South Australia, and is responsible for services to approximately 28% of the SA population. The communities served vary widely in size, population mix, proximity to larger centres and health needs. This is consistent with other country health services in Australia, which report similar challenges in providing health services to rural and remote areas.

To assist in overcoming these challenges CHSA released the *Strategy for Planning Health Services in Country SA* (Appendix 1) in 2008. The strategy defines some key principles to underpin health service planning in country SA, including:

- '*Facilitating access to services as close as possible to patients' support networks (family and friends)*' and
- '*In order to provide health services in a safe environment, the Government must support adequate levels of clinical staff, facilities and equipment to meet the current health care standards. Staff will be supported to have appropriate access to training, facilities and equipment to ensure skills remain at a high level.*' as principles underpinning planning.

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<sup>5</sup> Runciman WB, Roughead EE, Semple SJ, et al. Adverse drug events and medication errors in Australia. *Int J Qual Health Care* 2003;15 Suppl 1:i49-59.

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Further, the *SA Health Care Plan 2007 - 2016* identifies the development of four general hospitals in country SA, at Berri, Port Lincoln, Mt Gambier and Whyalla, with increased services available in these centres. The development of 11 clinical networks across SA Health has also resulted in a larger focus on country patients and the need for increased services in country SA.

Specific factors that influence the need for increased pharmacy services in CHSA are:

1. **An ageing population.** This is particularly relevant to country SA where it is reported that *'...there are more older people (compared to metropolitan SA) and the percentage of the population living beyond the age of 65 is expected to rise from the current 15% to 22% in 10 years' time.*<sup>6</sup>
2. **An increase in the number of people with chronic diseases.** In South Australia forty percent of people have at least one chronic disease and an estimated fifteen percent have two or more chronic diseases<sup>6</sup>.
3. **An increase in the prevalence of obesity.** In country SA *'the obesity rate is nearly 6% higher than in metropolitan Adelaide – 25% compared with 19% in the city'*<sup>6</sup>.
4. **The prevalence of smoking in country SA.** *'In 2007, smoking prevalence in metropolitan Adelaide was 18.2%, but in country South Australia it was 6% higher at 24.2% Smoking is a major cause of illness and disease in our community.'*<sup>6</sup>
5. **Increased complexity of care.** This is particularly true of the delivery of renal dialysis and oncology services, with many sites across country SA either starting to deliver these services or increasing the current level of service provision.

These factors will influence the demand for pharmacy services in regional and rural communities over the next decade and consideration needs to be given to how to develop pharmacy services to meet current and future needs in the context of the Pharmacy Reform agenda.

## 4. The Project

In 2009, Country Health Executive agreed to undertake a project considering the potential opportunities afforded by the Pharmacy Reform agenda. Due to the added complexity of pharmacy services in country SA, the original project was broadened to better reflect the need to understand models in place and the opportunities to build on these models to meet current and emerging needs.

The revised project objectives were to:

- Evaluate the nature and extent of pharmacy service delivery to SA country hospitals
- Identify barriers to increasing quality use of medicines in country SA
- Make recommendations to improve pharmacy service delivery, with a particular emphasis on the quality use of medicines component of the Reform
- Evaluate the potential to introduce PBS to relevant country hospitals.

### 4.1. Guiding Principles

The following key documents were identified and used as benchmarks to guide an evaluation of current pharmacy services in CHSA:

- **Guiding Principles to Achieve Continuity in Medication Management**  
(10 guiding principles) - Australian Pharmaceutical Advisory Council (APAC)

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<sup>6</sup> *'Strategy for Planning Country Health Services In SA (December 2008)*, South Australian Department of Health

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These principles are:

1. Leadership for medication management
  2. Responsibility for medication management
  3. Accountability for medication management
  4. Accurate medication history
  5. Assessment of current medication management
  6. Medication action plan
  7. Supply of medicines information to consumers
  8. Ongoing access to medicines
  9. Communicating medicines information
  10. Evaluation of medication management
- **EQUIP 4 Guide** - The Australian Council on Healthcare Standards  
Standard 1.5.1: Medications are managed to ensure safe and effective practice  
(Appendix 2)
  - **Strategy for Planning Country Health Services In SA (SA Health, December 2008)** (Appendix 1)
  - **SA Health Directive** (Reference no. D0174)  
Pharmaceutical Reform: Policy for Public Hospitals  
Effective January 2010 (Appendix 3)

### 4.2. Method

To enable a comprehensive understanding of current pharmacy service delivery models operating in country SA and to provide a basis for consideration of future growth, a number of methods for gathering information were used including:

- Consideration of relevant literature and guidelines
- Survey sent to all CHSA sites
- Site visits to a representative sample of 15 health units, as well as teleconferences with a further 2 sites (see Table 1 below)
- CHSA Pharmacy Forum with key stakeholders on 29 April 2010
- Regular meetings with SA Health Pharmaceutical Services and Strategy Unit
- Liaison with Country Health SA Drug and Therapeutics Committee.
- Discussions with other jurisdictions regarding pharmacy service delivery models in interstate country hospitals
- Liaison with leads of the oncology services reviews

Initially a survey was sent to all hospital sites, which asked general questions about how pharmacy services were delivered, as well as the scope of pharmacy services and the satisfaction level with service delivery. There was a response rate of approximately 60% to the survey. (Appendix 4).

In addition to this survey, site visits were conducted at fifteen hospitals across CHSA (Appendix 5). These hospitals were chosen based on size, location (including proximity to metropolitan Adelaide) and cluster and are outlined in Table 1. Standard questions were asked at each hospital visit (Appendix 6).

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Table 1

Site	Cluster	No. of Acute Beds
<b>Country General Hospitals</b>		
Whyalla	Whyalla, Eastern Eyre and Far North	82
Mount Gambier	Lower South East	78
Berri (via teleconference)	Riverland	48
Pt Lincoln	Eyre and Western	50
<b>Larger Community Hospitals</b>		
Pt Augusta	Pt Augusta, Hawker, Quorn, Leigh Creek, Roxby Downs and Woomera	82
Pt Pirie	Pt Pirie, Mid North, Southern Flinders and Pt Broughton	54
Murray Bridge	Mallee Coorong	46
Gawler	Inner North Country	49
Angaston	Inner North Country	26
Clare	Yorke and Lower North	25
Wallaroo (via teleconference)	Adelaide Hills, Southern Fleurieu and KI	21
Millicent	Lower South East	25
<b>Local Health Services</b>		
Balaklava	Yorke and Lower North	22
Tumby Bay	Eyre and Western	10
Cleve	Whyalla, Eastern Eyre and Far North	12
Kingston SE	Upper South East	9
Strathalbyn	Adelaide Hills, Southern Fleurieu and KI	15

Further, a forum was held on 29 April 2010 for relevant stakeholders to discuss country pharmacy services (Appendix 7). Attendees included representatives from:

- CHSA Chief Pharmacists
- Directors of Nursing
- Pharmacy Guild of Australia
- Pharmaceutical Society of Australia
- Contracted service providers (Hospital Pharmacy Services and RGH Pharmacy Consulting Services)
- Aboriginal Health Council of South Australia (AHCSA)
- Chair, Metropolitan Hospitals Chief Pharmacists Forum
- SA Health Chief Pharmacist
- SA Health Senior Project Officer, Pharmaceutical Reforms
- Project Team - CHSA Principal Allied Health Advisor, Cluster Director, Director of Nursing, a senior Pharmacist with considerable experience in both metropolitan hospitals and country community pharmacies and the Project Manager.

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Regular meetings were also held with the SA Health Pharmaceutical Services and Strategy Branch to ensure that the project was aligned to statewide pharmaceutical projects and initiatives. Likewise consultation occurred with medical experts delivering services to CHSA.

Throughout the research phase of the project, there was frequent contact with the Executive Officer of the Country Health SA Drugs and Therapeutic Committee and other relevant internal stakeholders including representatives from Finance and Quality and Safety departments (Appendix 8).

## 5. Findings and Recommendations

### 5.1. Service Models

Hospitals in Country Health SA receive pharmacy services via a variety of service models. This variation in service models is reflective of the solutions devised at a local level to ensure pharmacy services are available to patients.

Table 2 provides an overview of the five major models of pharmacy service delivery that are currently in place across CHSA. It describes the role of CHSA staff, the local community Pharmacist and the contracted pharmacy provider in each model. It should be noted that in addition to these models, outreach services support a number of very small remote communities.

**Table 2**

CHSA Staff	Community Pharmacist	Contracted Provider
<b>Model 1 - Hospital Pharmacy Department staffed by CHSA Staff (Mt Gambier, Pt Pirie)</b>		
Pharmacists: <ul style="list-style-type: none"> <li>▪ Procurement of medicines for the hospital</li> <li>▪ Discharge medicines education for patients, including written information</li> <li>▪ 7 days worth of discharge medicines</li> <li>▪ Review of inpatient medicines charts as time permits</li> <li>▪ Pharmacist are on call after hours in Mt Gambier, but not Pt Pirie</li> <li>▪ Services aged care residents in Pt Pirie but not Mt Gambier</li> <li>▪ Nursing staff education provided as time permits</li> <li>▪ Checking of expiry dates</li> <li>▪ Support for local Drug and Therapeutics Committee</li> <li>▪ Formulation and overview of local policy on therapeutics</li> </ul>	<ul style="list-style-type: none"> <li>▪ Provides services to aged care residents in Mt Gambier</li> </ul>	N/A

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CHSA Staff	Community Pharmacist	Contracted Provider
<b>Model 2 - Hospital Pharmacy Department staffed by contracted provider</b> (Whyalla and Pt Augusta)		
N/A	N/A	<ul style="list-style-type: none"> <li>▪ Procurement of medicines for the hospital</li> <li>▪ Discharge medicines and education for patients, including written information (where time permits)</li> <li>▪ Review of inpatient medicines charts as time permits</li> <li>▪ In Pt Augusta – extensive outreach to Aboriginal Community Health Centres</li> <li>▪ Nursing staff education provided as time permits</li> <li>▪ Stock management</li> </ul>
<b>Model 3 - No pharmacy department, services delivered by visiting contracted provider</b> <i>The amount of time pharmacists spend on site varies from 3 hours a month (smaller hospitals) to two days a week (larger hospitals)</i>		
Nurses: <ul style="list-style-type: none"> <li>▪ Receive stock and monitor the imprest</li> </ul>	<ul style="list-style-type: none"> <li>▪ At some sites community pharmacists will provide after hours medicines to the hospital</li> </ul>	<ul style="list-style-type: none"> <li>▪ Procurement of medicines for the hospital</li> <li>▪ Review of medicines charts (generally small proportion of total patients checked). Depending on the site, this may be current patients or a retrospective audit of past patients</li> <li>▪ Nursing staff education provided as time permits</li> <li>▪ Checking of expiry dates</li> <li>▪ Support for local Drug and Therapeutics Committee</li> <li>▪ Formulation and overview of local policy on therapeutics</li> </ul>
<b>Model 4 - No pharmacy department, services delivered by local community Pharmacist</b> <i>Some sites have formal contracts and remuneration structures in place, while at other sites services are provided free of charge with no written contract in place.</i>		

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CHSA Staff	Community Pharmacist	Contracted Provider
Nurses: <ul style="list-style-type: none"> <li>▪ Receive stock and monitor the imprest</li> </ul>	<ul style="list-style-type: none"> <li>▪ Procurement of medicines for the hospital</li> <li>▪ Review of medicines charts (generally small proportion of total patients checked). Depending on the site, this may be current patients or a retrospective audit of past patients</li> <li>▪ Nursing staff education provided as time permits</li> <li>▪ May be available after hours</li> </ul>	N/A
<b>Model 5 - Hybrid - Hospital staff/ Community Pharmacist.</b> <b>Hospital staff procure medicines, the local community pharmacist provides onsite services for approx. 1 hour/day</b> (Pt Lincoln)		
Supply Manager: <ul style="list-style-type: none"> <li>▪ Procures medicines</li> <li>▪ Nurses:</li> <li>▪ Order for ward imprest from central imprest</li> </ul>	<ul style="list-style-type: none"> <li>▪ Monitors the central imprest and provides Purchasing Officer with a list of medicines to procure</li> <li>▪ Provides QUM services on request as time permits</li> </ul>	

It was noted that the model for Whyalla and Port Augusta was originally the same as the model for Port Pirie and Mount Gambier (Model 1), but issues with recruiting pharmacists led to a decision to contract external providers of pharmacy services.

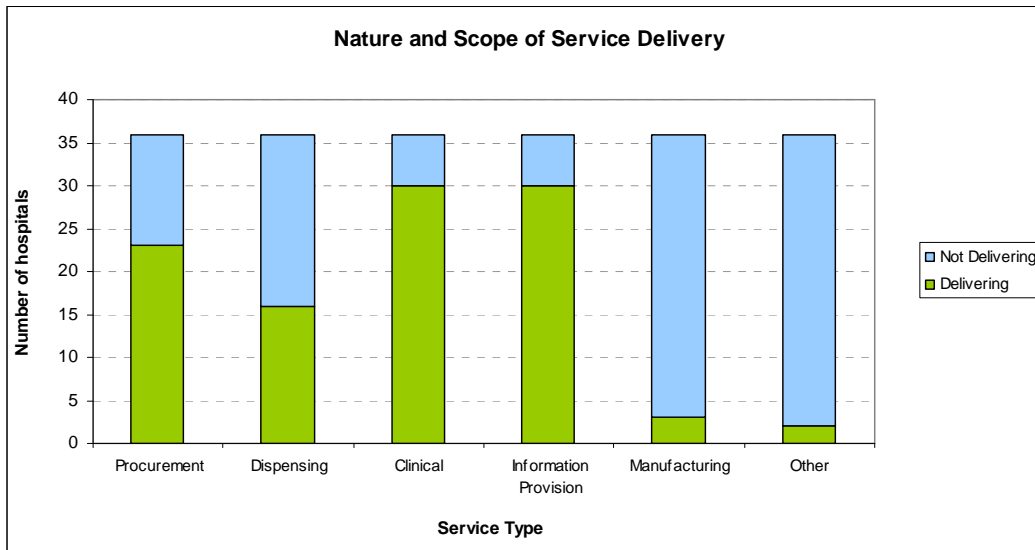
Further some sites use a combination of Models 3 and 4, with the local Community Pharmacist providing medication and the contracted provider delivering QUM services or vice versa.

Graph 1 (below) represents the survey results. Of the 33 sites surveyed, 27 considered the level of service they were receiving to be adequate. However site visits identified that in many cases QUM services were not adequate when making a comparison to the standards set out in the *APAC Guiding Principles to Achieve Continuity in Medication Management*. Likewise, many of those sites visited reported that there was a need for a greater level of clinical pharmacy services. This was contrary to the results of the survey in which a majority of sites reported that they received clinical pharmacy and information provision services and reflects the level of understanding and therefore expectations of the role of clinical pharmacy services in achieving quality use of medicines.

The survey also revealed that approximately half of those who responded dispensed medication and a small number reported they were involved in manufacturing. This information was not confirmed as site visits generally demonstrated that services outside of the basic supply of medication were inconsistent and limited.

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Graph 1



There is great variability in the time dedicated to pharmacy services across sites, with some sites receiving a few hours a month of services, and others having dedicated pharmacy services that include on call services. It should be noted that some but not all of the variance is due to the size of the hospital.

There were commendable models of service delivery including QUM in a minority of hospitals surveyed and/or visited. Two examples of this are services at Wallaroo and Strathalbyn where the needs of the hospital were being met through extensive service delivery from local community pharmacists. These higher levels of service provision were a result of higher expenditure compared to other CHSA sites. This highlights the inconsistencies in pharmacy service budgets due to local determination rather than a centralised decision-making process.

The variety in models described is reflective of historical differences in localised service development and the varying needs of communities in country South Australia. Each model has its strengths and should be considered in appropriate locations.

Onsite pharmacies provide appropriate services in larger hospitals. However, current staffing levels limit the pharmacists' capacity to use their skills effectively in providing clinical pharmacy services to improve QUM. It is considered that in some sites the pharmacy staffing is too low to be sustainable (one or two pharmacists) given the legal responsibilities of service provision and the corresponding clinical risks.

The onsite pharmacy model also gives the opportunity to provide outreach services to smaller hospitals and to remote communities, with the current Port Augusta service effectively demonstrating this support to a range of communities. Employment of staff in the onsite pharmacies varies between all staff employed by CHSA to hybrid models where some staff are employed by a contractor and some by SA Health to all staff being employed by the contractor.

For smaller hospitals, visiting services from contractors were considered most effective where there was consistency in the pharmacist providing the service so a relationship with the hospital could be developed. It was noted that where there was inconsistency of staffing and differences in skill levels of the visiting staff that this model can be problematic. There is an opportunity to overcome this variability through the introduction of consistent contracts with

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appropriate Key Performance Indicators across all sites. Further, support should be given to continue relationships with current providers as long as KPIs aligned to QUM can be met.

As noted above there are some excellent models of services provided by community pharmacists in medium to small hospitals. Such models have the advantage of continuity of care for patients who access the community pharmacy when not in hospital. Where relationships and capacity in the community pharmacy sector permit, this model should be retained and supported in smaller communities provided they are able to meet the relevant KPIs.

### 5.2. Medication incidents

Incidents regarding medication error are recorded in SA Health on the AIMS system. In SA Health, medication error is the second most commonly reported incident, after falls. Until recently this system was not configured in such a way that would allow good analysis of variations in incident levels between hospitals however on a Regional level data shows that CHSA has more than twice the incidence of medication error than Southern Adelaide Health Service (SAHS) Region which serves a similar population. In the period July 2009 to May 2010 CHSA reported 1717 incidents compared to 917 reported by SAHS. While some of this discrepancy may be due to an extremely good reporting culture in CHSA the disparity is significant given the evidence already noted regarding the impact of clinical pharmacy services in reducing medication incidents.

During consultations, some staff expressed a belief that larger country hospitals with higher throughput may be more at risk of medication incidents than smaller hospitals, however at this time systems do not allow this to be verified.

The new configuration of AIMS and the soon to be introduced new incident reporting system for SA Health will allow much more detailed analysis in the future.

### 5.3. Purchasing and distribution of medications

Overall it was found that the supply and distribution of medicines is relatively efficient. High priority was given to ensuring that patients have timely access to relevant medicines, despite the various medication suppliers, method of purchasing and hospital staff involved. Generally it was found that where medication was urgently required staff approached other hospitals in the cluster, the local community pharmacist or metropolitan hospitals to gain access to medications. In some cases this could lead to a delay in medication supply of up to 24 hours. Further findings include:

- The financial benefits associated with the State pharmaceutical contracts are not fully realised, often due to a lack of awareness of the ability to access these contracts. The better use of these contracts or of a single supplier could represent savings to CHSA.
- Inadequate communication about medication information during the transfer of patients from metropolitan hospitals can disrupt the continuity of medication administration. The introduction of liaison nurses in metropolitan hospitals has had a beneficial impact on continuity of care; however there is no consistent formalised communication process for ensuring that country sites have relevant patient medicines in stock. A small number of individual hospitals have developed effective processes to ensure efficient patient transfers.
- Further, variability exists regarding the payment of medications supplied at transfer from the metropolitan hospital. In some cases there is no charge, while in other cases the receiving hospital or the patient is billed.

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- Significant metropolitan hospital financial and staffing resources are currently spent on the transportation and posting of medicines to ambulatory patients at country hospitals. This is because there are currently no specialist public outpatient clinics in CHSA from which these medicines could be supplied.

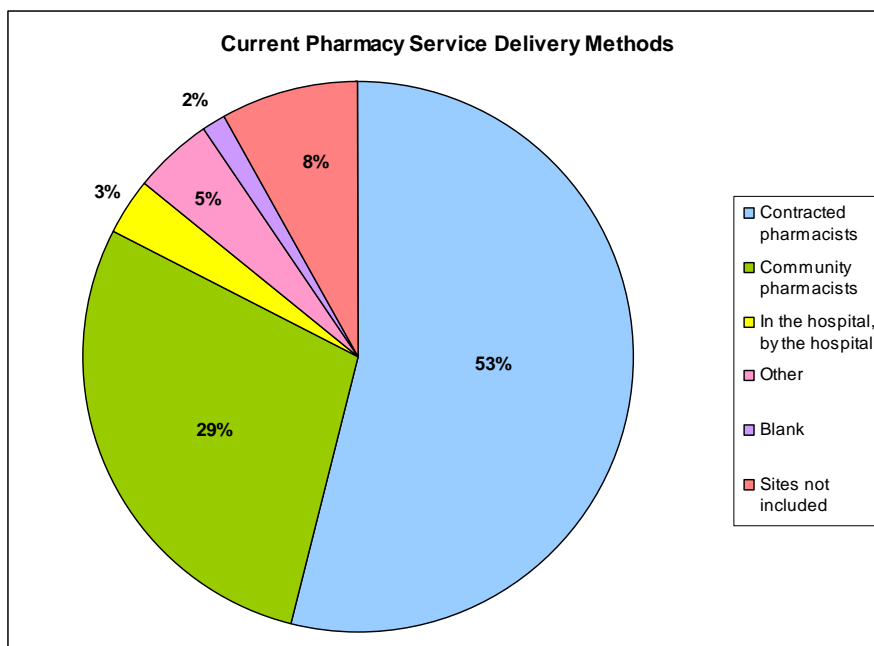
### Recommendations

1. That consideration be given to a more uniform approach to the purchasing of medications
2. That systems be reviewed to ensure that patients transferred between hospitals have timely access to medications

### 5.4. Contracts for pharmacy services

Graph 2 (below) provides an overview of the methods of pharmacy service delivery in country SA. The source of this data is a combination of survey results, site visits, contractor reporting and cluster audits. It shows that a majority of hospitals purchase services from contractors (53%), followed by local community pharmacies (29%). Approximately 3% of sites have pharmacists directly employed by Country Health SA. The majority of contracted services are delivered by one provider, but through multiple contracts.

Graph 2



Historically, individual health services have contracted (where appropriate) services directly from a contractor or a local pharmacy. Generally contracts have been negotiated between the Director of Nursing and the provider, without the assistance of procurement expertise. This has led to vast variations in the way in which services are contracted including:

- A minority of hospitals do not have written contracts in place for pharmacy services, with services being provided on a goodwill basis
- Some contracts include Key Performance Indicators for the service provider, but others do not. It was found that where KPIs had been included in the contract, these were generally not being met in the area of quality use of medicines. This was because effective monitoring and management of contracts was challenging for time poor local hospital staff

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- There is significant variation in the negotiated hourly rate for pharmacy services. It was noted that some local community pharmacists provide their services free of charge.
- The duration of contracts varies across CHSA. It was noted that capacity at a local level to monitor dates and renegotiate contracts varies greatly. A number of contracts have expired, which creates the risk that providers may choose to discontinue services to CHSA at any time. The Strategic Procurement Unit is aware of this risk and that different contracts are in place for pharmacy services in CHSA. The Unit is committed to the development of a robust procurement framework to improve the current contract process, including the provision of contract management services to CHSA.

### Recommendations

3. CHSA sites move to more consistent level of pharmacy service provision to meet health service needs.

4. That Country Health SA in conjunction with the Strategic Procurement Unit introduce consistent contracts for pharmacy services across CHSA and that these contract be managed centrally. Further, that the positive relationships that have been established between country hospitals and local community pharmacists/contracted provider should be preserved where possible

### 5.5. Quality use of medicines

The APAC *Guiding Principles to achieve continuity in medication management* (July 2005) assert that:

*‘There are two essential components to ensure the quality use of medicine across the health care continuum. The first is to establish standards of practice that define standard operating procedures (Guiding Principle 1). The second is to identify the positions or person, working within the accepted limited of their roles, who are responsible for implementing each step of the process (Guiding Principles 2 and 3)’*

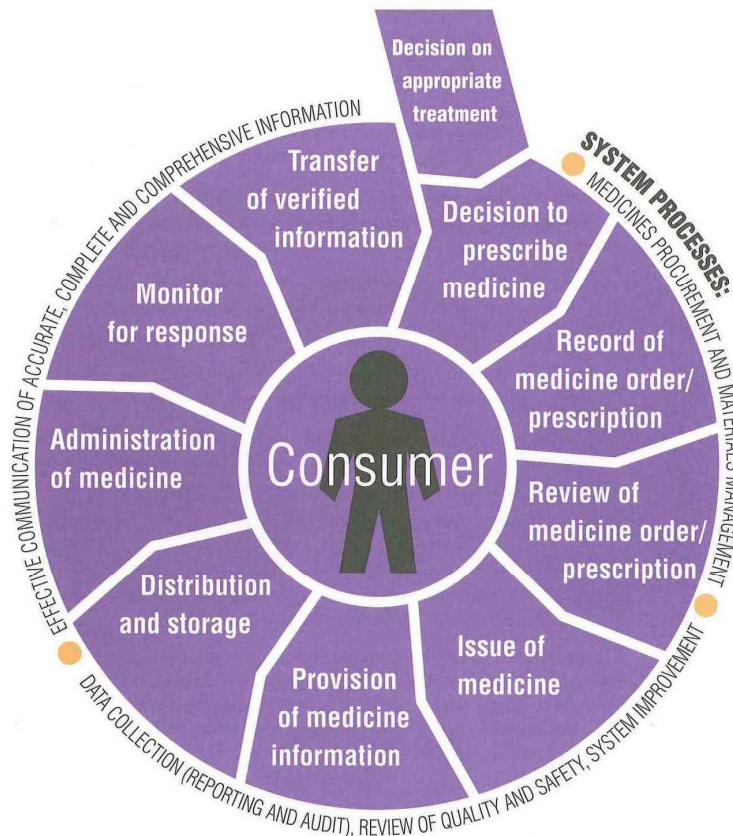
Presently, staff in CHSA are challenged by both of these components of ensuring QUM. This is because the task of establishing standards of practice has by default been the responsibility of pharmacists working in pharmacy departments and existing staffing levels are based on dispensing rather than clinical pharmacy services.

There is not currently the opportunity for coordinated effort and robust systems which would efficiently support the implementation of standards, so to date progress has been disjointed and ad-hoc. The lack of a co-ordinated focus has impaired the identification of positions to work towards the achievement of these standards, particularly in those sites without a dedicated pharmacy department. Those sites that have a pharmacy department have been more easily able to identify resources to undertake QUM roles, but report that current staffing allows little capacity to undertake QUM tasks. This situation is similar to that in metropolitan hospitals prior to the Reform, but retention and recruitment difficulties and the time and effort required to fill vacancies has more of an effect in country areas.

The implementation of quality use of medicines throughout the patient’s episode of care is depicted in Figure 1 (below). It shows that there are nine key components of medication management relating to the consumer and highlights the importance of appropriate systems to support pharmacy processes.

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Figure 1



Taken from *Guiding Principles to achieve continuity in medication management*, July 2005 – Australian Pharmaceutical Advisory Council

The nine components of QUM through the medication management cycle indicate the role of the whole health team in improving QUM and are underpinned by the 10 *APAC Guiding Principles to Achieve Continuity in Medication Management*. An examination of current capacity in CHSA to achieve these 10 principles revealed:

Table 3

APAC Principle	Comments
Guiding Principle 1 - Leadership for medication management	No leadership across CHSA to ensure that systems and resources exist to support QUM and continuity of care
Guiding Principle 2 - Responsibility for medication management	The level of staffing resources in CHSA do not allow for this
Guiding Principle 3 - Accountability for medication management	No consistent policies and procedures in place and no leadership/governance over QUM
Guiding Principle 4 – Accurate medication history	No consistent identified person/role (eg. Pharmacist, GP or Nurse) identified in CHSA to take medication histories No consistent way of taking medication histories (eg. Template) Patient medication histories provided from GP clinics using

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APAC Principle	Comments
	electronic records such as Medical Director on admission were frequently reported to be out of date.
Guiding Principle 5 – Assessment of current medication management	Generally across CHSA medication chart checks are either not consistently performed, or performed in a minority of patients. Some exceptions to this in specific CHSA sites.
Guiding Principle 6 - Medication action plan	Action plans not used in CHSA due to lack of resources
Guiding Principle 7 – Supply of Medicines Information to Consumers	No formalised process to ensure that patients receive up-to-date written and verbal education about their medication on discharge.
Guiding Principle 8 – Ongoing Access to Medicines	At those hospitals where there is no onsite pharmacy, patients generally do not receive a supply of drugs at discharge. This system can be problematic if patient is discharged after hours or on the weekend when the community pharmacy is not open.
Guiding Principle 9 – Communicating Medicines Information	Information about changes to the patient’s medication regimen that occur whilst an inpatient may not be reported back to the primary health care provider. Inconsistency in reporting of medication information and drug supply when patients transferred from metropolitan hospitals.
Guiding Principle 10 - Evaluation of medication management	Inconsistency in reporting of medication information when patients transferred from metropolitan hospitals. Where patients are released from country hospitals with prescriptions, there is no mechanism to know whether prescriptions are filled.

Specific examples of where the benchmarks for the QUM are not being met include:

- There is inconsistency in the way in which a patients’ medication history on admission is taken. Patient medication histories provided from GP clinics using software such as Medical Director, were reported to frequently be out of date, eg. include all medicines prescribed to that the patient over an extended period of time, rather than current medication.
- Generally medication chart checks are either not performed, or performed in a minority of patients. Discussion with some sites did, however, reveal a few exceptions where high level clinical pharmacy services are provided by local community pharmacy. Further, some sites have a system where nursing or medical staff can request a review be conducted.
- There is no formalised process to ensure that patients receive appropriate written and verbal education about their medication on discharge. Further, many sites do not have easy access to suitable information to provide to patients on discharge. A limited number of sites have access to e-MIMs, while Mt Gambier has a database that can be tailored for individual patients. Many sites expressed the need for an electronic database that provides patient appropriate medicines information.
- At those hospitals where there is no onsite pharmacy, patients generally do not receive a supply of drugs at discharge. Patients are either given a prescription to be

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dispensed at the local pharmacy or the prescription may be faxed directly to the community pharmacy. This system can be problematic if the patient is discharged after hours or on the weekend when the community pharmacy is not open. There is also no way of knowing whether patients collect these medicines.

- There is no consistent formalised process across CHSA for ensuring that information about changes to the patient's medication regimen that occur whilst an inpatient be reported back to the primary health care provider.
- There is limited opportunity for appropriate continuing education for nursing and pharmacy staff due to time pressures on pharmacy providers.

### Clinical pharmacy services in other Australian hospitals

Information from The Society of Hospital Pharmacists of Australia (SHPA) reveals that in line with the Pharmacy Reform agenda there has been a shift in the way in which pharmacists in hospitals spend their time, with a greater focus on ensuring continuity of care and a more co-ordinated approach to medication management. In particular SHPA<sup>7</sup> reports:

- 47% of a pharmacist's time is spent outside the pharmacy department working alongside other health professionals on clinical pharmacy services for individual patients (**e.g. admission medication history interviews, medication management review, therapeutic drug monitoring, medication counselling / patient education, providing drug information to doctors / nurses and the training and education of pharmacy students and others**). These pharmacy services are known to reduce adverse medication events.
- 16% of a pharmacist's time is devoted to management services that also improve **patient safety system-wide** through developing prescribing policies, quality activities such as medicine use evaluation, standardisation of high risk medicines, staff education etc.
- the remaining 37% of time is devoted to supply of medicine services that include specialised manufacture (sterile and non-sterile including cancer chemotherapy), clinical drug trials dispensing and services to support optimal storage of medicines, prevention of selection errors and appropriate labelling and packaging.

These figures contrast with the current service delivery focus of staff in CHSA, where staff report spending a majority of their time dispensing medications, rather than providing clinical pharmacy services. This difference was described by one pharmacist as the result of addressing a hierarchy of needs in which a limited number of resources needed to be directed toward the patient receiving medication, with any additional time then directed toward clinical pharmacy services. It is likely that this contributes significantly to the retention and recruitment challenges<sup>8</sup> faced by CHSA in particular; when professionals are not able to use their full range of skills and undertake the work for which they have been trained this results in lower job satisfaction. It should be noted that in the metropolitan hospitals where the reforms have been implemented, large numbers of applicants apply for positions whereas in country it is usual to get very few applicants and these are often not suitable for the role.

The experience of CHSA is similar to that experienced by metropolitan hospitals in SA where prior to the Reform it was reported that hospitals had a significantly lower average ratio of

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<sup>7</sup> Media release from SHPA dated 30 April 2009, *Pharmacy practice change confirmed in Australian hospitals*

<sup>8</sup> National Rural Health Alliance, (2004), *Under Pressure and Under-valued: Allied Health Professionals in Rural and Remote Areas*, accessed at [www.ruralhealth.org.au](http://www.ruralhealth.org.au)

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clinical pharmacists to beds (1 to 90) compared to States that have successfully implemented the Reforms. For example, the average ratio of clinical pharmacists introduced in the metropolitan Victorian hospitals to adopt the Reforms was 1 to 30-40 and in Queensland 1:40. A decision was made, therefore, that a significant number of additional clinical pharmacists would need to be recruited in to the hospital system. Metropolitan SA hospitals that have adopted the Reform now have a clinical pharmacy ratio of 1 to 30-40 beds (depending on the hospital). The only CHSA pharmacy department in CHSA that was reported to have dedicated clinical pharmacy services when an analysis was undertaken by the SA Health Pharmaceutical Services and Strategy unit in 2008 was Port Augusta (see table 4). It should be noted that the Full Time Equivalent FTE staffing allocated to clinical pharmacy services at this site was minimal at the time of the analysis.

### **Staffing at hospitals with a pharmacy department**

As noted in the *Strategy for Planning Country Health Services in SA (December 2008)*,

*There is an increasing expectation of high-quality, safe clinical services, and hospitals and health services are always considering ways to improve. Modern health care is a complex and dynamic process which needs processes and systems to deliver high-quality services. Safety and quality is linked to a range of factors, such as adequate staffing, education and training, appropriate infrastructure and equipment.'*

This statement is particularly pertinent to pharmacy services in CHSA, where it was observed that there were limited supports in place, including adequate staffing and professional development to allow the achievement of the principles of quality use of medicines, especially in the context of growing services as CHSA starts to achieve the aim of providing more services closer to where people live.

Sites with onsite pharmacy departments reported that, similar to metropolitan hospitals prior to the introduction of the Reform, there are currently not enough pharmacy positions to ensure that quality use of medicines principles were in place. This was supported by modelling performed as part of the Reform by Pharmaceutical Services and Strategy Branch (see Table 4 and Appendix 9) and independently by Pt Augusta Hospital which showed that additional pharmacy staff were needed in CHSA hospitals if the APAC quality use of medicines guidelines were to be met. The modelling used at Pt Augusta, Whyalla, Pt Pirie and Mt Gambier was the same modelling used to support the establishment of 77 clinical pharmacy positions in those metropolitan hospitals that have adopted the reform and was based on 2008 bed use figures.

Please note that as exact figures for time currently spent on QUM activities is not available, estimates have been used where possible.

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**Table 4 Additional staffing required to achieve QUM**

Hospital	Current staffing (providing dispensing and limited clinical services)	QUM Services Currently Provided	Recommended additional clinical pharmacist staffing to achieve QUM (as per the Pharmaceutical Services and Strategy Unit in 2008)	Estimated Difference (Recommended additional staffing minus estimated current QUM effort)	Recommended minimum additional pharmacist staffing to initiate/ expand Clinical Pharmacy Services (as per current project)
Mount Gambier Hospital	1 FTE X AHP5* 1FTE X AHP3 1FTE X AHP2 1 FTE X AHP1 Pre-registration pharmacist (non-secured funding) 2.4 FTE technicians	<ul style="list-style-type: none"> <li>• QUM services provided as time permits (&lt; 1 FTE)</li> <li>• 7 days of discharge medications given</li> <li>• Significant pharmacist time spent checking chemotherapy medications</li> </ul>	2.78 FTE + 1 FTE graduate	Approx 1.9 FTE + 1 FTE graduate	1 FTE + 1 FTE graduate in subsequent year
Whyalla Hospital	Services provided by contractor 1FTE Pharmacist 2FTE Assistants	<ul style="list-style-type: none"> <li>• QUM services provided variable based on capacity of staff member employed</li> <li>• History on admission generally done by GP or Nurse</li> <li>• Patients given 3-4 days worth of discharge drugs</li> <li>• Currently very few chart checks done</li> <li>• No after hours/weekend services</li> </ul>	2.68 FTE + 1 FTE graduate	Estimate 2 FTE +1 FTE graduate	1 FTE + 1 FTE graduate in subsequent year
Port Pirie Hospital	1FTE X AHP3 1FTE X AHP2 0.8 FTE Assistant	<ul style="list-style-type: none"> <li>• Daily chart checks done on 1 ward</li> <li>• 7 days of medication on discharge</li> <li>• No after hours services by pharmacist – nurse manager has</li> </ul>	2.22 FTE + 1 FTE graduate	Estimate 1.8 FTE + 1 FTE graduate	1 FTE + 1 FTE graduate in subsequent year

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Hospital	Current staffing (providing dispensing and limited clinical services)	QUM Services Currently Provided	Recommended additional clinical pharmacist staffing to achieve QUM (as per the Pharmaceutical Services and Strategy Unit in 2008)	Estimated Difference (Recommended additional staffing minus estimated current QUM effort)	Recommended minimum additional pharmacist staffing to initiate/ expand Clinical Pharmacy Services (as per current project)
	0.7FTE Assistant	access to pharmacy department			
Port Augusta Hospital (PAH)	1.2 FTE Pharmacists 1.0 FTE Pre-registration Pharmacist (non-secured funding) 2.0 FTE Assistants <ul style="list-style-type: none"> <li>Contractor employs the Pharmacists and Pre-registration Pharmacist.</li> <li>Port Augusta Hospital employs the Assistants.</li> </ul>	<ul style="list-style-type: none"> <li>Discharge counselling for all patients who get medication from onsite pharmacy (ie.not PBS)</li> <li>~50% hospital patients receive cursory clinical services as staff resources allow</li> <li>Renal Unit patients receive QUM services spasmodically as staff resources allow</li> </ul>	3.22 FTE + 1 FTE graduate (noted some clinical pharmacist services already in place)	Estimate 2.2 FTE + 1 FTE graduate	1 FTE + 1 FTE graduate in subsequent year
Port Augusta Hospital outreach services <sup>#</sup>	0.8 FTE Pharmacist 1 FTE assistant	<ul style="list-style-type: none"> <li>Regular onsite visits (generally monthly) including patient review/counselling, in-service lectures, nursing staff support.</li> </ul>	Current SA Health formula does not accommodate outreach models	Current SA Health formula does not accommodate outreach models	Not yet established – further work required.

\* The Pharmacy manager position in Mt Gambier is currently classified at AHP5 for historical reasons however is likely to be classified at AHP4 when reviewed prior to next being appointed, especially if a CHSA Clinical Lead pharmacy position is established

<sup>#</sup> Port Augusta outreach provide all drugs, supplies and regular professional pharmacy services to : *Roxby Downs HS, Woomera HS, Oodnadatta HS, Marree HS, Quorn HS, Andamooka HS, Leigh Creek HS* and surrounding communities including Aboriginal Health Services.

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The discrepancy between recommended staffing levels under APAC modelling and those recommended by this project is a reflection of the need to stabilise current staffing and therefore build a platform for the recruitment of further staff including pre-registration pharmacists in the near future.

Subject to funding being identified it is proposed that in the first year of implementation of a CHSA pharmacy service framework that 1FTE additional pharmacist be provided at Pt Pirie, Mt Gambier, Pt Augusta and Whyalla and that a pre-registration pharmacist be employed at each of these sites in the second year to capitalise on the increased number of pharmacy graduates now available and address future sustainability.

### **Staffing at new general hospitals**

Currently, the developing general hospital sites at Berri and Pt Lincoln purchase pharmacy services from external providers. The level of service offered by these providers is limited by the contracts currently in place and funding identified for these.

Increased services are being developed at both sites, and it is anticipated that this will increase the need for clinical pharmacy services. Modelling should consider both the level of clinical pharmacy services required to provide QUM services to the current activity and also to the proposed new services which include chemotherapy and increased dialysis chairs at both sites.

Should services continue to be provided under the current arrangement at these sites, the level of service provision will need to increase to ensure that an appropriate level of clinical pharmacy services is provided. This would have cost implications for both sites, which are currently purchasing services via an hourly rate scheme.

Alternatively, there is the potential to develop onsite pharmacy departments at these sites. This may be more cost effective in terms of directly employing staff rather than paying for contractors, and would also allow these sites to undertake PBS dispensing, which would create revenue for CHSA. This option would have cost implications in terms of start-up infrastructure costs. It is proposed, therefore, that a thorough cost/benefit analysis of potential models be undertaken.

### **5.6. Use of National Inpatient Medication Chart**

A major national initiative to improve the safe use of medicines was the standardisation of medication ordering in hospitals through the National Inpatient Medication Chart (NIMC). The NIMC was mandated for use in all hospitals within Australia by the Australian Health Ministers Advisory Council (AHMAC) by June 2006. The widespread use of electronic prescribing systems/medical records by general practitioners (GPs) servicing country hospitals has made the introduction of the NIMC into country hospitals more difficult. An electronic version of the NIMC has been developed and is compatible with the electronic prescribing systems used by GPs. However it was noted there is:

- poor uptake of the NIMC in country hospitals
- a lack of awareness of electronic versions of the NIMC
- a reported lack of support by some General Practitioners for the use of the NIMC
- potential medication safety issues due to difficulty in reading hand written drug orders.

Concern was also expressed about the lack of access to OACIS and the safety and patient care characteristics of this system by country health care providers.

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## Recommendation

5. That strategies to encourage the use of the National Inpatient Medication Chart (NIMC) across country SA hospitals be further developed

## 5.7. Clinical leadership

As noted previously, the APAC guidelines identify leadership as a key contributor to achieving QUM. Currently the only leadership available in this area in CHSA is the Drug and Therapeutics Committee.

A review of the draft Terms of Reference for the CHSA Drug and Therapeutics Committee (DTC) identifies that the role of the Committee is to *'promote and provide advice to Country Health SA and its hospitals/health services on the safe, appropriate and cost-effective use of drugs and therapeutics in country South Australia.'*

Interview questions about the CHSA DTC at site visits revealed:

- The majority of sites visited knew that CHSA had a Drug and Therapeutics Committee, but were unsure of the role of the Committee and had very little interaction with the Committee
- The sites that had representatives on the DTC felt that the Committee would benefit from having clearer terms of reference and greater decision making ability.
- More guidance from the DTC in relation to medication management is needed
- There is a lack of a formal authoritative process for the introduction of new medications and policies

Further, the Chair of the DTC identified the need for and value of dedicated pharmacy participation on the Committee. It was also suggested that improved communication between metropolitan based drug and therapeutics committees, in particular the newly established South Australian Medicines Advisory Committee (SAMAC) (Appendix 10) and those that are country based would help in supporting country hospital pharmacy services. Given that the key role of SAMAC is to improve the quality use of medicines in SA, such a relationship can only benefit the achievement of QUM in country SA and formal links are recommended.

There is an opportunity to revise the terms of reference of the CHSA Drug and Therapeutics Committee to align with the recommendations of this project. In particular there is a need for the CHSA Drug and Therapeutics Committee to have greater decision making ability to efficiently formulate, implement and monitor policies and procedures relating to therapeutic substances in country SA.

### Clinical Pharmacy Lead

There is a need for a Clinical Lead position to be created in Country Health SA to oversee the implementation, monitoring and evaluation of improvements to pharmacy services. This role would work closely with the Country Health SA Drug and Therapeutics Committee to create consistent policies and procedures across Country Health SA as well as having a service provision role.

The role would also be responsible for the development of consistent reporting of pharmacy services including financial reporting. Enhanced reporting would allow better comparisons between sites in the future and create an opportunity for best practice models to be identified. Learnings from best practice models may lead to greater efficiencies and savings in service delivery across other CHSA sites. Further, greater reporting will allow the evaluation the impact introducing APAC Principles across CHSA in the future, as well as the ability to conduct a costs/benefit analysis of introducing PBS to CHSA.

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The Clinical Lead role would be responsible for liaising with the Strategic Procurement Unit to develop consistent pharmacy contracts in CHSA, including an auditing and contract management framework.

Further, it is important that the Clinical Lead develop relationships with metropolitan Pharmacists and pharmacy groups to ensure that there is minimal duplication of effort and that communication of Statewide pharmacy initiatives occurs. The clinical leadership position would:

- Provide clinical input and support to the Strategic Procurement Unit in the introduction of consistent and relevant contracts for pharmacy services to CHSA
- Co-ordinate the provision of non-commercial pharmaceuticals which negate the need for onsite manufacturing facilities
- Develop consistent pharmaceutical policies and procedures in conjunction with the CHSA drug and therapeutics committee
- Provide clinical support services to pharmacists providing services in CHSA
- Ensure adequate monitoring of quality standards
- In year 2, review impact of additional staffing on QUM and assess current staffing levels compared to methodology used for implementation of APAC in metropolitan services and specific country needs e.g. outreach services.
- In year 3, review impact of improved contracting on access to QUM in hospitals without onsite pharmacists.

This model is in line with the Dietetic Profession Lead role and the Chronic Conditions Lead Podiatrist role in CHSA, which are already proving effective in addressing quality issues and improving Statewide linkages to the benefit of country residents and CHSA staff.

### Recommendation

6. That pharmacy services to country hospitals move toward meeting APAC guidelines, in line with metropolitan hospitals which have adopted the Reform
7. That current CHSA pharmacy departments be further developed to increase clinical pharmacy capacity both locally and across country to meet QUM.
8. That clinical pharmacy services be introduced to Berri and Port Lincoln and further analysis regarding the appropriateness of onsite pharmacy or other models be undertaken
9. That a pharmacy Clinical Lead role be introduced to CHSA
10. That the role, function and membership of the CHSA Drug and Therapeutics Committee be reviewed to strengthen it's ability to lead implementation of QUM including implementation of the NIMC

### 5.8. Recruitment and retention of pharmacy staff in CHSA

The *Strategy for Planning Country Health Services in SA* (December 2008) states that

*'Health services in country South Australia provide health care for almost 430,000 people living in 1200 cities, towns and small communities across almost one million square kilometres. Distance, remoteness and isolation impact on service delivery and are important considerations in our commitment to recruit and retain medical, nursing and midwifery, and allied health staff, and support people to access the most appropriate health care services.'*

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Difficulty in recruiting and retaining pharmacists, other allied health professionals and indeed professionals in general in rural and remote communities is well documented and the subject of considerable investigation. An in depth review of literature relating to this issue in Victoria was undertaken in 2005.<sup>9</sup> The messages from this review were:

- Personal factors are the strongest influences in the decision to be recruited to a rural location
- Professional / occupational factors dominate decision making about staying in rural practice
- Mixed 'personal' and 'professional' factors are most influential on the decision to leave

As part of this review more in depth analysis of specific professions was undertaken and for pharmacy the following key work values were identified, based on the Australian Job Search website<sup>10</sup>

*'Work values are global aspects of work that are important to a person's satisfaction. The list of values that received at least 9 out of 10 from pharmacists are:*

- *Ability utilization – make use of their individual abilities*
- *Achievement – get a feeling of accomplishment*
- *Security – have steady employment*
- *Working conditions – have good working conditions*
- *Social status – are looked up to by others in their company and their community.'*

The National Rural Health Alliance, in its position paper on rural and remote allied health professionals identifies that *'By supporting allied health professionals ..... and providing them with opportunities to maintain and increase their skills, retention rates are increased.'*<sup>11</sup>

Pharmacists working in SA country hospitals expressed concerns that were consistent with the evidence identified above. They discussed difficulties with access to clinical support, that low numbers of staff meant that more senior staff are not always available when advice is needed, and frustration with not being able to apply their skills effectively due to the demand for dispensing and minimal time available for clinical pharmacy provision.

Over recent years difficulty in recruiting pharmacists to country SA has resulted in the contracting out of pharmacy services in Whyalla and Pt Augusta hospitals. Mt Gambier and Pt Pirie hospitals continue to experience difficulties in attracting appropriate staff in spite of an increase in the number of pharmacy graduates in recent years and considerable efforts by the local management. Strategies to attempt to assist in recruitment, such as application of a 20% loading for temporary contracts at AHP3 level, have to date had limited success and have created some difficulties due to disparity with other positions. It is possible that strategies such as this may be part of the solution, but are not effective in isolation.

Despite the professional isolation and additional challenges of operating in country areas, many hospital-based pharmacists reported a high level of job satisfaction. Contributing factors were reported to be:

- The wide ranging scope of roles and responsibilities available to pharmacists, including the option for outreach in some sites

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<sup>9</sup> Human Capital Alliance (2005) Recruitment & Retention of Allied Health Professionals in Victoria – A Literature Review

<sup>10</sup> Australian JobSearch (2005), <http://www.jobsearch.fov.au/JobExplorer>

<sup>11</sup> National Rural Health Alliance, (2004), Under Pressure and Under-valued: Allied Health Professionals in Rural and Remote Areas, accessed at [www.ruralhealth.org.au](http://www.ruralhealth.org.au)

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- Support from and interaction with local drug and therapeutics committees and clinicians
- The ability to build strong relationships with the community and hospital staff due to the relatively small size. Likewise it was reported that Pharmacists had good access to hospital executives which facilitates decision making
- Recognising and addressing challenges often as a sole professional confers significant professional satisfaction, but can also be frustrating due to the limited structures identified above.

Considerable progress has been made in SA Health and CHSA in improving ability to attract and retain allied health staff in rural and remote locations over the last few years. The number of allied health professionals employed in CHSA has increased from approximately 360 in June 2006 to almost 500 in June 2010. This translates to an increase in FTE from 260 to 406

The recently implemented SA Health Wages Parity (Salaried) Enterprise Agreement 2010 addresses one of the major obstacles to recruitment identified, which was the disparity in pay scales between SA and other States. The implementation of a separate schedule for allied health professionals in this agreement has provided an improved career structure and resulted in an average 4-6% increase in pay for staff. It is recognised that pharmacy faces an additional barrier in relation to remuneration given the large number of pharmacists employed in the private sector and the pay available in this sector.

To date these improvements have had little impact on pharmacy but the strategies introduced for other professions should be considered in addressing the current difficulty experienced by the CHSA sites in attracting and retaining staff. These include networking of professionals across country, introduction of clinical leadership and/or specialist roles, development and commencing introduction of a clinical support framework, introduction of a Clinical Enhancement Program. While many of these strategies are already available to CHSA pharmacists, due to the small numbers of staff it has been difficult to ensure that access is available.

With the introduction of a Clinical Lead role in CHSA, there is an opportunity to explore consistent and transparent approaches to pharmacist recruitment and retention strategies. Such a strategy should include consideration of:

- Pharmacy departments having a minimum of two pharmacists on staff
- Professional support to pharmacists servicing country hospitals including mentoring arrangements with metropolitan hospitals and access to professional development
- A consistent orientation program for new staff
- The establishment of pre-registration pharmacist positions to facilitate recruitment
- Liaison with Universities to explore the expansion of country clinical placements including innovative models that will minimise additional workload for the host sites.
- Recognition of the broad range of responsibilities of the Chief Pharmacist positions at country hospitals in the level of classification/remuneration (AHP 4)

### Recommendations

11. That the clinical lead position be charged with the responsibility to develop recruitment and retention strategies for country SA pharmacists.

12. That recruitment and retention strategies recognise the advantages of working in rural areas and build on these, while addressing professional isolation and other issues.

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### 5.9. The provision of pharmacy services to Aboriginal clients

Although this project did not focus specifically on pharmacy services to Aboriginal people, these patients were identified as being at higher risk.

Aboriginal clients make up a significant proportion of the population being served at some sites, with this number increasing. Meeting the needs of this population requires a higher level of resources and different approach to service delivery when compared to the general population. Specific findings include:

- Pt Augusta offers a committed and effective outreach program for pharmacy services to Aboriginal communities. Improvement in outcome measures, such as improved compliance with medications, have been demonstrated through this program<sup>12</sup>.
- Outreach services are required given the distances involved and the inability and at times reluctance of some Aboriginal people to present at hospitals
- Specific requirements of pharmacy services include different medication education approaches (including written/pictorial information) and the provision of dosage administration aids.
- Pt Augusta outreach is currently reliant on separate funding, which may be problematic in the future in terms of ongoing funding for the program. The extension of such outreach services to other CHSA hospitals should not be reliant on non-permanent external funding.
- The legislated changes (July 2010) to the patient contribution payment for medicines by Aboriginal and Torres Strait Islander patients with a chronic disease may have a detrimental impact on the supply of medicines and associated counselling at the time of discharge from a public hospital. Under these changes, a patient contribution fee will be required for PBS medicines supplied by a public hospital, but not by a community pharmacy.

There is, therefore, an opportunity to explore improvements to pharmacy services to Aboriginal patients. It is recommended that liaison occur with organisations such as AHCSA to assist in assessing the needs of this patient group so that services can be appropriately tailored. This may include an increase in the range of outreach services at various hospitals. There is also an opportunity to build on best practice models currently operating in CHSA, such as outreach services to Pika Wiya.

Further consideration and exploration of the impact of the proposed July 2010 legislation changes to patient contributions should also be undertaken.

#### Recommendation

13. That specific, culturally appropriate services for Aboriginal people be further developed in collaboration with relevant stakeholders

### 5.10. Cytotoxic therapies in CHSA facilities

Currently, a number of reviews of oncology services are being undertaken in South Australian hospitals. This project team was asked to assist these reviews by collecting information relating to the supply and administration of cytotoxics at country hospitals.

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<sup>12</sup> An evaluation of the Home Medicines Review (HMR) process at the Pika Wiya Aboriginal Health Service (PWHS), September 2009, Amanda Sanburg

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CHSA is already experiencing a growth in cancer services and more growth is anticipated. This will need to be managed and attention will be required to the most effective way to accommodate this growth. To this end this project report makes some general observations only and more depth analysis will be required over time.

A large number of sites reported that cytotoxics were being given and growth in such therapies had occurred and would continue to occur. Cytotoxics administered in country hospitals are acquired from metropolitan hospitals or private suppliers. It was reported that the timeliness of delivery of these agents was at times an issue. Differences between hospitals in many aspects including cytotoxic supply, adjunct medication therapies such as high cost anti-emetics, quality of patient information, payment for cytotoxics delivered from metropolitan hospitals and the administration of the cytotoxics were identified.

It was also identified that the management and administration of cytotoxics was time consuming for both nursing and pharmacy staff and that current funding models did not adequately cover this cost. Improvement in communication regarding changes in protocols and other relevant information could strengthen the efficiency and safety of cytotoxic administration.

It should be noted that discussions with Victoria and Tasmania revealed that similar challenges in these States have led to decisions that cytotoxic infusion therapies only be administered at larger country hospitals which have an onsite pharmacist and quality systems in place.

On 18 May 2010, the Commonwealth Government announced it would spend approximately \$85 million on improvements to cancer services in regional SA (Appendix 11). This will include a new regional cancer centre in Whyalla and *'...will form part of a state-wide network of 11 chemotherapy units across country SA, with funding of \$5.4 million towards the establishment of chemotherapy units in the 10 other rural and regional sites: Mt Barker, Mt Gambier, Port Augusta, Victor Harbor, Clare, Murray Bridge, Gawler, Northern Yorke Peninsula, Naracoorte and Port Lincoln.'*

Implementation of these new services will require appropriate attention to standards and staffing requirements. Due to the infrastructure required, the need for specifically trained staff and the rigorous standards to be met CHSA does not intend to manufacture chemotherapy drugs in its facilities and that view is supported by this project.

### Recommendation

14. That the findings of this project be considered in Cytotoxic Therapy reviews currently being conducted in SA

15. That where cytotoxics are to be delivered and administered in CHSA facilities the appropriate infrastructure and staffing that optimises quality & safety must be in place.

### 5.11. Aged care services in CHSA

In all but one hospital medication for aged care facilities was managed separately to the acute care beds. Overall preliminary findings were that medication to aged care facilities work relatively well in country SA. However, this review did not focus specifically on medication service delivery to residential aged care facilities in CHSA and further analysis may be beneficial in this area. It is recommended that should this occur services be measured against *the APAC Guidelines for Medication Management in Residential Aged Care Facilities.*

Specific findings were:

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- Medications for aged care residents were supplied in Dosage Administration Aids, such as Webster packs. In most locations, this service was provided by the local community pharmacy and payment for this service was made either by the hospital or the resident.
- Separation of acute and aged care medication management permits access to Commonwealth funding including Residential Medication Reviews.
- Overall the potential and actual level of medication review in aged care facilities is greater than that for acute care patients.

### 5.12. Implementation of PBS in CHSA

There is the potential to create revenue for CHSA through the introduction of PBS and outpatient dispensing. An analysis undertaken to determine potential revenue from implementing PBS dispensing in those hospitals with onsite pharmacies found that:

- The initial estimate, based on recent patient discharge data only, suggests annual revenue of approximately \$440,000.
- This revenue will not be sufficient to allow complete implementation of the APAC guidelines across those sites which currently have a hospital pharmacy, but would offset costs
- The relative lack of outpatient clinics impacts on potential PBS revenue as well as having financial and convenience impacts on patients needing ongoing medicines initiated in metropolitan hospitals
- There is significant emergency department activity in country hospitals and variability in models of drug supply to such patients. In house dispensing of such medications may provide further PBS revenue for country hospitals.
- There is an expectation expressed that central funding was to be made available to facilitate the introduction of the Pharmaceutical Reform to country hospitals.
- If PBS dispensing is introduced to country hospitals, appropriate infrastructure will be required as was the case in metropolitan hospitals.

Although some preliminary estimates have been completed regarding potential revenue from introduction of PBS in CHSA, a more comprehensive cost/benefit analysis is needed for each site individually. Introduction of PBS will require additional staffing above the new pharmacists recommended to address QUM. Such an analysis should be conducted on all general hospitals including those currently developing, as well as those hospitals which currently have onsite pharmacy departments.

Further, there is an opportunity to explore the introduction of increased outpatient services including dispensing in country SA. Access to outpatient services would:

- Decrease the need for patients/families to travel to Adelaide to access services
- Create efficiencies for both country and metro hospitals (eg. Posting and handling of medication by metropolitan hospitals, potential for PBS revenue, no need to contact metropolitan hospitals to access medications)
- Potentially increase the revenue from PBS for sites with an onsite pharmacy department
- Facilitate greater equity in payment for medicines between country and metropolitan patients.

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## Recommendation

16. That an in depth cost/benefit analysis of introducing PBS and outpatient dispensing to individual Country Health SA pharmacy departments be undertaken

## 6. A whole of CHSA ‘virtual’ pharmacy service

Given the strengths identified in current models, but the current lack of capacity to address QUM in CHSA and the inconsistency of patient experience of pharmacy services, the following framework for a ‘virtual’ pharmacy service across country is proposed.

In the larger hospitals, existing onsite pharmacies should be strengthened to enable progress towards achieving QUM within the hospital, in surrounding areas and across country. Additional FTE should be developed and linked with Key Performance Indicators (KPIs) that relate to the achievement of APAC Guidelines within the facility, the surrounding Health Units where applicable and across country.

For the next level of hospitals, consideration should be given to the level of clinical pharmacy services required using the same formula applied to modelling pharmacy needs for metropolitan hospitals and the existing onsite pharmacies. This is particularly relevant when considering the developing General hospitals in Berri and Port Lincoln, but also for the Inner Country sites such as Gawler or Murray Bridge which have similar bed numbers and increasing demand. Services to these larger sites, whether through onsite pharmacies (with employed or contracted staff) or contracted services, due attention should be given to the recommended staffing levels.

Smaller health units should receive visiting services either as

- outreach from a facility with an onsite pharmacy
- through a pharmacy contractor
- from a local pharmacy.

These services must be guided by contracts which

- are managed centrally with the assistance of SPU
- have KPIs relating to both supply and QUM which are consistent across country (but appropriate for individual sites) and are monitored regularly in relation to quality, safety and financial performance
- KPIs should also include access measures that consider the patient journey and the experience of country residents in accessing medications.

Where the service is provided from a facility with an onsite pharmacy managed by CHSA, this would take the form of a service level agreement but contain similar parameters.

Consistent policy and procedures should be developed to ensure that KPIs can be met in a manner which is as consistent as possible and which minimises the time spent by local pharmacy staff in duplicating systems.

More detailed work on financial implications needs to be completed, but it is anticipated that cost savings from improved procurement of medications, access to PBS revenue generated within country, support from PBS revenue being generated by metropolitan hospitals, and savings to metropolitan hospitals through provision of clinical and pharmacy services closer to home for country residents will all contribute to the cost offsets available.

To implement such a virtual service the following timeline is suggested:

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## Year 1

- Appointment of a Clinical Lead role as previously defined
- A review of the current Terms of Reference of the CHSA Drug and Therapeutics Committee, including greater decision making ability and relationship with SAMAC
- Appointment of 4 FTE additional pharmacists, one at each of the existing sites
- Access state-wide contracts for procurement of medications
- Self assessment of sites against APAC Guidelines
- Development of consistent contracts / KPIs and comment implementation
- Development of consistent policies/procedures
- In depth analysis of potential models for Berri and Port Lincoln
- In depth cost/benefit analysis of PBS opportunities at sites with existing onsite pharmacies, including both inpatient activity and outpatient/emergency department activity

## Year 2

- Appointment of 1 FTE pre-registration (graduate) pharmacist to each of the existing sites
- Commence implementation of enhanced services for Berri and Port Lincoln
- Review impact of increased staffing on ability to meet QUM and assess against recommended levels
- Re-assessment of sites against APAC guidelines (self assessment)

## Year 3

- Evaluate impact of changes including assessment against APAC guidelines
- Review impact of improved contracting on access to QUM at sites without onsite pharmacies
- Develop targets for years 4 & 5

The recommendations of this report will provide a pathway for CHSA to move towards achieving the benchmarks relating to quality and safety of pharmacy services, with the aim that QUM standards should be reached within 5 years.

## 7. Financial implications of recommendations

Preliminary estimates have been completed regarding the potential financial implication of implementing the recommendations in this report and have been outlined in Table 5 (below).

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Table 5

Current situation	Proposed changes	Estimated cost	Potential cost offset
<b>Year 1</b>			
<p><b>Staffing</b></p> <p>4 FTE pharmacists + 2.4 FTE technicians Mt Gambier            2 FTE Pharmacists + 1.5 FTE assistants Port Pirie            1 FTE pharmacist + 2 FTE assistants Whyalla            3 FTE pharmacist + 3 FTE assistants Pt Augusta (including outreach)</p>	<p>Additional 1 FTE per site with existing pharmacy (4 sites)            1 FTE Clinical Lead</p>	<p>\$379,248 (Full year cost – based on AHP205)            \$120,351 (Full year cost – based on AHP501)</p>	<p>Potential to access metro PBS profits</p>
<p><b>Contracts</b></p> <p>Multiple contracts with same provider and individual contracts with community pharmacists            Medications purchased differently at different sites – often state contracts not accessed</p>	<p>Access State-wide contracts for purchase of medications            Improve consistency of contracts with community pharmacists and other contractors</p>	<p>The approximate value of current contract was not able to be ascertained from financial data available.</p>	<p>There is potential for costs savings in the purchasing of medications via statewide contracts or other arrangements</p>
<p><b>Access to PBS dispensing on discharge</b></p> <p>Nil</p>	<p>In depth analysis per site</p>	<p>Not yet known</p>	<p>Based on preliminary calculations for inpatient activity only, minimum revenue from PBS in current onsite pharmacy departments is estimated at \$440,000</p>
<p><b>Outpatient and Emergency Department dispensing</b></p>	<p>In depth analysis per site</p>	<p>Not yet known</p>	<p>There is potential for additional</p>

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Nil			revenue from outpatient PBS dispensing in sites with onsite pharmacy departments.
<b>Year 2</b>			
<b>Staffing</b>			
Limited pre-registration pharmacist positions	Additional 1FTE per site with existing pharmacy (4 sites)	\$240,016 (Full year cost – Based on AHP102)	Potential to access metro PBS profits
Increase in pharmacy services Berri and Port Lincoln (new clinical pharmacy services)	Estimate 2 FTE Berri Estimate 2 FTE Port Lincoln	\$390,024 (Full year cost - Based on one AHP 301 and one AHP 401 at each site) if provided onsite (more analysis required)	Offset against existing contracts and potential PBS revenue
<b>Access to PBS dispensing on discharge at Berri and Pt Lincoln</b>			
Nil	In depth analysis per site required	Not yet known	Potential for additional revenue from outpatient and ED dispensing in Pt Lincoln and Berri
<b>Outpatient and Emergency Department dispensing at Berri and Pt Lincoln</b>			
Nil	In depth analysis per site required	Not yet known	Potential for additional revenue from outpatient PBS dispensing in Pt Lincoln and Berri

### 8. Conclusion

CHSA hospitals access pharmacy services through a variety of models and face a number of challenges in providing consistent, quality pharmacy services. Some good practice models have been developed which address these challenges and there is potential to learn from and build upon these models. This report has identified that no one model best meets the needs of all CHSA facilities. However, characteristics of models that work well have been identified and discussed in relation to community size, complexity and purchasing arrangements

At this time CHSA facilities have very limited capacity to implement the APAC QUM guidelines as required under the Commonwealth Government Pharmaceutical Reform. Attention to workforce needs is critical to achieving this aim. This report recommends recruiting a Clinical Lead role and increasing the capacity at existing onsite pharmacies to allow for commencement of more systematic implementation of QUM across country.

The recommendations of this report will provide a pathway for CHSA to move towards achieving the benchmarks relating to quality and safety of pharmacy services, with the aim that QUM standards should be reached within 5 years. It is recognised that this would require additional investment, but that there are potential cost offsets such as PBS dispensing.

A suggested framework which considers CHSA pharmacy services as a 'virtual' service across all of country, with consistent standards, policy and procedures focused on improving the patient journey is provided.

## Appendix 1 – Alignment with Strategy for Planning Country Health Services in SA

### Principles for country health service planning

#### **1. Focusing on the needs of patients, carers and their families utilising a holistic care approach. [SASP Objective 2] :**

- ✓ > Having the health of patients and communities as the primary objective of all health service planning.
- > Developing models of service delivery that identify and support carers and families.
- ✓ > Enabling patients, carers and their families to understand and be partners in the planning and delivery of their health care by providing information as to where and how to effectively access required support.
- ✓ > Facilitating access to services as close as possible to patients' support networks (family and friends).
- > Providing culturally sensitive services based on the needs of Aboriginal people.
- > Recognising the needs of people from culturally and linguistically diverse backgrounds.
- ✓ > Encouraging greater self-responsibility for health care.
- ✓ > Improving the coordination and integration of services so as to present a complete system of health care to the patient.
- > Achieving an appropriate balance of in hospital/out of hospital primary and preventative health care services.
- > Increasing the focus on wellbeing and the development of primary health care strategies.
- > Improving the level of population health initiatives such as early intervention and illness prevention services.

#### **2. Ensuring sustainability of country health service provision. [SASP Objectives 5 and 6]**

- ✓ > Defining and ensuring essential levels of service delivery for all country hospitals and health services, in consultation and agreement with local communities.
- ✓ > Facilitating adequate and timely staffing of health care teams within all country hospitals and health services so that agreed service levels can be provided.
- ✓ > Actively recruiting, expanding and retaining a skilled resident general and specialist medical, nursing and midwifery, allied health and ancillary health workforce.
- > Recognising the important social and economic contribution hospitals and health services make to their local communities.
- > Recognising the important contribution of volunteers.
- ✓ > Developing, supporting and evaluating innovative models of care to meet the changing needs of local communities.
- ✓ > Resourcing of infrastructure (facilities and equipment) of all country hospitals and health services so that agreed service levels are provided and maintained within local communities.

#### **3. Ensuring effective engagement with local communities and service providers. [SASP Objective 5]**

- > Supporting communities to be involved in consultation processes by ensuring they are provided with necessary information and given an understanding of the issues they are considering.
- > Supporting the understanding and development of "health literacy" in communities.
- > Supporting the development of community participation strategies including engagement, education and awareness.
- > Changing health service profiles will only occur following open, formal and documented community consultation and agreement.
- > Engaging and consulting with Health Advisory Councils, Aboriginal Health Advisory Committees and other relevant local community networks.
- > Identifying, engaging and consulting with all parts of the health workforce in rural communities, e.g. private practice clinicians, visiting service providers and staff.
- > Engaging and consulting with the Aboriginal Health Council of South Australia and Aboriginal

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Community Controlled Health Services.

> Engaging and consulting with peak rural health professional organisations including RDWA, RDASA, AMA (SA), ANF (SA Branch), GPSA and rural Divisions of General Practice, PSA, Adelaide to Outback GP Training, Greater Green Triangle GP Education and Training, Sturt Fleurieu GP Education and Training, CRANA, the RFDS, SARRAH and others<sup>3</sup>.

### **4. Improving Aboriginal health status. [SASP Objectives 4,5 and 6]**

- ✓ > Closing the gap in Aboriginal health life expectancy.
- > Recognition of self-determination as a key social determinant of health.
- ✓ > Recognition of and respect for Aboriginal Community Controlled Health Services (ACCHS) as a major partner in improving the health of Aboriginal people in South Australia.
- ✓ > Local partnerships, accountability and shared responsibility.
- > Engaging communities in the design and delivery of services, including the development of community capacity. Aboriginal community participation (and service delivery to Aboriginal people) should be developed in accordance with the principles established at the Virru Wimila kidney meeting on the Iga Warta homeland in May 1999, and consequently known as the Iga Warta Principles. Aboriginal Elders play a critical role in communities and this role will be respected in maintaining community engagement.
- ✓ > A holistic approach across the life cycle, using family-centred models.
- ✓ > Flexible and accessible models of Aboriginal health that are based on need and equity to all South Australians, including Aboriginal Australians.
- > Evaluation of programs on overall capacity to achieve measurable outcomes in the standards and quality of programs, community engagement and leadership.
- ✓ > The need for adequate and sustainable funding to provide a secure context for setting goals, particularly in aligning resources with the specific disadvantages faced by Aboriginal people.
- ✓ > Better communication with other health providers including AHCSA4 and Aboriginal Community Controlled Health Services.
- > Recognition of the important role that symbolism contributes, such as “welcome to country” ‘ and “acknowledgement of country” at events or flying the Aboriginal flag.

### **5. Contributing to equity in health outcomes. [SASP Objectives 2 and 6]**

- ✓ > Providing health services as close to patients' homes as possible without compromising safety and quality of health care.
- ✓ > Facilitating adequate and appropriate transport and accommodation, enabling efficient and effective access to health services and improving the “patient journey”.
- ✓ > Having effective and efficient patient care facilitated through integrated communication and information technology systems.
- > Developing service delivery profiles that are culturally appropriate, specifically for Aboriginal people.
- > Facilitating the needs of people from culturally and linguistically diverse backgrounds.
- ✓ > Enabling those who are most in need to utilise appropriate services.
- ✓ > Facilitating access by patients and locally-based health care teams to specialist advice and services.
- ✓ > Supporting appropriate access to general practice and primary health care services.

### **6. Strengthening the IT infrastructure. [SASP Objectives 2, 4 and 6]**

- > Facilitating the provision of clinical and business services and clinical decision-making supports.
- > Improving access to remote services through audio, visual and data transmissions.
- > Facilitating the application of IT for diagnostics and treatment
- > Strengthening support for local clinicians in emergency and chronic disease management.
- > Facilitating the sharing of clinical information.
- > Facilitating communication and information technology systems to enable transfer of patient information to assist in partnerships in care, including electronic record sharing and broadband connectivity between designated and approved country and/or metropolitan health providers.

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> Quality training for clinicians and consumers will be adequately resourced to ensure the effective use of information technology.

### **7. Providing a focus on safety and quality. [SASP Objective 2]**

- ✓ > Providing safe and high-quality health services.
- ✓ > Utilising best practice and evidence-based planning in decision-making and service planning, wherever possible.
- ✓ > Collecting accurate health service data to assist in workforce and service planning.
- ✓ > Providing resources to seek and identify evidence-based practice to consider future innovative clinical developments and changing workforce practices.
- ✓ > Analysing performance against appropriate national indicators and benchmarks.
- ✓ > Sustaining staff skill levels and supporting professional development (including procedural skill development).
  - > Including teaching, research and training in planning processes to provide greater opportunities for students, academics and researchers to learn and add to the body of health knowledge.
- ✓ > Promoting the unique opportunities for teaching and learning in rural environments.

### **8. Recognising that each health service is part of a total health care system. [SASP Objectives 2 and 4]**

- ✓ > Enabling integration and coordination of services to support links between Country General Hospitals, Country Community and Local Area Hospitals and Health Services, metropolitan hospitals, aged care facilities, medical, nursing and midwifery and allied health practitioners, statewide clinical networks and other community-based services.
  - > Enabling integration and coordination between local Health Advisory Councils.
- ✓ > Exploring opportunities with health organisations in both the public and private sectors, non-government organisations and the Commonwealth to further develop and enhance health services.
- ✓ > Ensuring clarity of roles and responsibilities of health care providers to enable a partnership approach between all stakeholders, providing the patient with a statewide integrated system to service their needs.

### **9. Maximising the best use of resources. [SASP Objectives 1 and 2]**

- ✓ > Enhancing effective relationships with other clinical and non-clinical services to ensure coordinated service delivery, maximising patient health outcomes and sharing of resources.
- ✓ > Ensuring efficient and effective patient pathways for patients to access the most appropriate health services.
- ✓ > Ensuring resources are used effectively and efficiently, including infrastructure and human resources, and balanced with the provision of services as close to home as possible.

### **10. Adapting to changing needs. [SASP Objectives 1, 2, 4, 5 and 6]**

- ✓ > Identifying and informing future health trends by accurately measuring current and historical health data, and considering current and future demographic trends, such as growth in communities associated with developments in mining, retirement and tourism.
  - > Providing practical and supported opportunities for flexible employment arrangements.
  - > Ensuring flexibility in health delivery systems allowing for future clinical and technological advances.
- ✓ > Allocation of sufficient time for planning, participation and execution of implementation processes.



The intent of this criterion is two fold. The criterion is designed to:

- reduce the incidence of error in the prescription and administration of medications to consumers / patients
- reduce the level of harm caused to consumers / patients in health care organisations by medication errors.

This criterion relates to all health care organisations that prescribe and / or administer drugs.

The use of medication remains the most common intervention in health care. Medicine misuse, underuse, overuse and adverse reactions annually result in an estimated 140,000 hospital admissions in Australia; most of these adverse drug events are preventable.<sup>1</sup>

There are several ways organisations can achieve safe use of medicines, one of which is the pathway described in the report *Improving Medication Safety* by the Australian Council for Safety and Quality in Health Care.<sup>2</sup> This pathway is described as a closed loop, comprising nine steps and three background processes, with the patient / consumer being the central focus of the pathway.<sup>3</sup> The concept can be applied regardless of the type of health professional involved or the care setting, such as in the consumers home, aged care facility, hospital, day procedure centre or community based care.

The **quality use of medicines** is defined as 'the judicious, appropriate, safe and effective use of medicines',<sup>4</sup> and should be the aim of every health service that has any role to play in the administration of medications.

A **medication error** may be defined as '...any preventable event that may cause or lead to inappropriate medication use or consumer / patient harm, while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures and systems including: prescribing, order communication, product labelling, packaging and nomenclature, compounding, dispensing, distribution, method of administration

– such as IV or oral, education, monitoring and use',<sup>5</sup>

All strategies aimed at reducing medication errors and the harm caused by medication errors should be focussed on reducing the complexity of processes by reducing the number of steps and promoting standardisation. Some of these strategies include:

- the introduction of standardised medication charting across the organisation
- the removal of high-risk medicines from patient areas
- the introduction of medication review.

A medication management system should:

- address medication safety across the continuum of care; from the community into the acute service and on return to the community
- cover all drugs, drug delivery devices, including infusion pumps with safety features, labelling processes and information transfer processes relating to drug therapy
- consider the choice of the drug distribution system, such as ward stock and supply system, bedside lockers, individually dispensed medicines or automated dispensing devices
- include a link to the risk management system and specifically the incident management system
- refer to the Australian Pharmaceutical Advisory Council's *Guiding Principles to achieve Continuity in Medication Management*.<sup>3</sup>

The Australian Commission on Safety & Quality in Health Care (ACSQHC) recommends the use of a **common medication chart**<sup>6</sup> across all health services in Australia.<sup>7</sup> Health care organisations are encouraged to implement a common chart in their health care organisation when possible.

**High-risk medicines** are those which if prescribed and administered incorrectly cause morbidity and mortality. They often have a small therapeutic range, for example, anticoagulants, intravenous potassium and insulin. Other medications can pose a high risk due to the possibility of them

being prescribed incorrectly such as sound alike names or multiple strengths. Australian alerts have been issued for some high-risk medicines with recommendations for actions.<sup>8,9</sup> A systems approach should be used to identify high-risk medicines within an organisation and strategies developed to reduce the impact.<sup>3</sup>

Health care organisations that prescribe and administer drugs should undertake **medication review**. This does not necessarily mean that a pharmacist must carry out this process, but that an individual consumer's / patient's medications are reviewed. In some organisations this will be carried out by a pharmacist and in others this will be carried out by the prescribing medical practitioner.

It is not expected that all organisations will have access to a **clinical pharmacist**, however, the clinical pharmacist applies specific pharmaceutical expertise to help to maximise medicine efficacy and minimise medicine's toxicity in individual patients. It allows pharmacists to become part of the clinical team and to anticipate medication errors. One of the pharmacist's traditional roles is of quality control, monitoring and reporting on errors only retrospectively. Clinical pharmacy is a move away from reactive quality control towards proactive involvement in direct consumer / patient care and the anticipation of errors, thereby reducing the incidence of harm to patients. Medication review on admission to a service can also identify whether an admission is due to prescribing errors or to adverse reactions to medicines in the community. Medication review on admission can help to identify such problems and report back to GPs. Medication review at discharge is key to providing accurate, complete and comprehensive medicines information to consumers / patients and to their community providers / GPs so that care may be continued.

Australian clinical pharmacy practice standards describe goals and procedures for ten activities aimed at optimising the use of medicines and patient outcomes. The three priority clinical pharmacy services are:<sup>10</sup>

- accurate medication history, including medication reconciliation on admission
- assessment of current medication management, including medication reconciliation at discharge
- provision of medicines information to consumers / patients.

To further assist safe use of medicines, Australian Health Ministers have called for every public organisation to have in place a process of pharmaceutical review of medication prescribing, dispensing, administration and documenting processes for the use of medicines.<sup>11,12</sup>

A health care organisation is responsible for ensuring that the culture exists for **medication management and reporting systems** within the organisation that enables the identification and notification of as many medication errors, near misses and adverse drug events and adverse drug reactions as possible. This is essential if potential risks are to be identified, evaluated and acted upon. Incident reports provide valuable information about incidents and near misses however; systems other than the incident information system should be in place to gather information about adverse drug events. These include health record reviews, audits, reviews of the literature and various reports.

In the future, electronic medication management systems that include decision support should sustain the safer use of medicines, along all steps of the medicines management pathway. In the interim, where appropriate, organisations may use currently available technology to reduce risk, such as use of bar codes and scanning devices with 'smart' safety features.

Consumers / patients can benefit from the National Prescribing Service (NPS) initiated consumer-focussed program that aims to provide information about medicines and to reinforce the importance of consumers working with their health care providers.<sup>13</sup>

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## Appendix 3 – SA Health Directive - Pharmaceutical reform: policy for public hospitals



**SA Health**

**Directive**

### ***Pharmaceutical reform: policy for public hospitals***

Ref. No.: D0174

Effective from: January 2010

Next Review: January 2011

**Functional groups** Governance and health services

- Summary** Conditions and policies for South Australian public hospitals participating in the pharmaceutical reform initiative including:
- the Pharmaceutical Reform Agreement between the Commonwealth and South Australian governments
  - reporting against milestones and key performance indicators to achieve continuity in medication management
  - a standard process for the dispensing and charging of medication.

**Responsible Division** Public Health and Clinical Coordination

**Contact person** Kaye Barratt, ph 8226 7240, Naomi Burgess, ph 8226 7375

**Applies to** SA Health, public hospitals only.

**Distributed to** SA Health – all divisions / branches / units  
All health units incorporated under the *Health Care Act 2008*  
SA Health – public hospitals

**File Number** 2009 – 08359

**Status** Approved

Chief Executive, Department of Health

**Compliance with this Directive is mandatory**

## Pharmaceutical reform: policy for public hospitals

### 1. Introduction

This policy directive establishes a standard process that is to be followed in all South Australian public hospitals engaged in the pharmaceutical reform initiative for:

- > participating in pharmaceutical reform
- > implementing the Australian Pharmaceutical Advisory Council's (APAC) guiding principles to achieve continuity in medication management
- > implementing the patient charges and business rules for dispensing medication.

### 2. Background

In December 2006, the South Australian Government agreed to accept an Australian Government offer to participate in a process of pharmaceutical reform in public hospitals. The reforms comprise a dual outcome:

- > access to medications via the Pharmaceutical Benefits Scheme (PBS) for outpatients, patients on discharge and for a range of chemotherapy medications for day-admitted patients and outpatients
- > implementation of the Australian Pharmaceutical Advisory Council's (APAC) guiding principles to achieve continuity in medication management.<sup>1</sup>

The key objectives of the pharmaceutical reforms are to improve:

- > equity of access to medication for patients regardless of their place of care – public hospital, private hospital or the community sector
- > safety and quality of medication management, including a smooth transition between hospital and community-based care.

Formal approval from the Chief Executive, SA Health is provided before hospitals can commence participating in the pharmaceutical reforms.

### 3. Definitions

The following definitions apply to this policy

- > Day-admitted patient - a patient who is admitted and separates on the same date.
- > Discharge - the process by which an episode of care for an admitted patient ceases.
- > Eligible person - the same meaning as in section 3 of the Health Insurance Act 1973 or any person that is treated as an eligible person under that Act – that is, an Australian resident or an eligible overseas representative.
- > Outpatient - a patient who is receiving an out-patient service.
- > Public hospital services - defined in the Australian Health Care Agreement (AHCA) as 'services of a kind or kinds (including admitted patient services and non-admitted services) that are currently provided, or were so provided on 1 July 1998...'

### 4. Policy

#### 4.1 Pharmaceutical Reform Agreement

The Pharmaceutical Reform Agreement ([Appendix 1](#)) sets out the conditions upon which certain pharmaceuticals may be provided to eligible persons. All participating hospitals are required to abide by the conditions contained in that agreement.

#### Participation

The conditions for a hospital to participate in the pharmaceutical reforms are:

- > The hospital may participate in the Chemotherapy Pharmaceutical Access Program (CPAP) provided they are also participating in the Pharmaceutical Benefits Scheme (PBS).
- > To participate in either the CPAP or the PBS:

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- > the hospital must be granted written approval for participation by the Chief Executive, SA Health, subject to such conditions as the Chief Executive deems necessary or convenient (see 4.3 – Patient charges and business rules)
  - > the Chief Executive, SA Health, must provide written advice to the Secretary of Health, Canberra
  - > the Australian Government and the South Australian Government must agree on the milestones for implementing the APAC guiding principles, as well as mechanisms for reporting and audit of the implementation effort (see 4.2 – APAC guiding principles).
- > The hospital must obtain approval as an approved hospital authority under section 94 of the National Health Act 1953.
- > PBS and CPAP
- Pharmaceutical benefits may only be prescribed to:
- > an eligible person who is an out-patient or patient on discharge from a participating hospital (PBS only)
  - > an eligible person who is receiving a day-admitted patient service from, or is an outpatient of, a hospital that provides public hospital services to that person (CPAP only).

The conditions for supplying pharmaceutical benefits in accordance with the PBS and CPAP are set out in the Pharmaceutical Reform Agreement.

The conditions for payment for the supply of these pharmaceutical benefits are set out in the Pharmaceutical Reform Agreement.

The SA Health Chief Pharmacist will maintain a register of hospitals approved by the Chief Executive for participation in the Pharmaceutical Benefits Scheme and the Chemotherapy Pharmaceutical Access Program.

### 4.2 APAC guiding principles

A public hospital participating in the reforms must implement the APAC guiding principles and meet the agreed milestones.

To facilitate this work, SA Health has provided seeding funds to hospitals to recruit human resources, including sufficient to raise the ratio of clinical pharmacists to beds to the national standard<sup>2</sup> (as referenced in the APAC guiding principles). Metropolitan hospitals must maintain this standard as a minimum. The number of graduate trainee pharmacist positions has also been increased to support recruitment and retention and must be maintained as a minimum.

Other models of practice will be employed in rural and remote areas where pharmacy services are not delivered by the hospital.

#### Reporting

##### > APAC milestones

The milestones have been agreed between the Australian Government and the South Australian Government. Hospitals participating in the pharmaceutical reforms are expected to achieve the milestones within the timeframes indicated from commencement of claiming PBS reimbursement.

Hospitals will report achievement of the milestones to the pharmaceutical reforms team, Safety and Quality Unit, SA Health, under the hospital performance agreements. They will then be reported to the Special Access Programs Branch, the Department of Health and Ageing, Canberra by Intergovernment Relations Unit, SA Health.

##### > APAC key performance indicators

The key performance indicators (KPIs) measure the impact of implementing the APAC guiding principles. The KPIs evaluate improvements in medication management from a health service and consumer perspective. They are to be reported annually to the pharmaceutical reforms team, Safety and Quality Unit, SA Health, under the hospital performance level agreements.

#### Supporting documents

The milestones and KPIs are available as an appendix to this policy directive

- > APAC milestones for South Australian public hospitals implementing pharmaceutical reforms ([Appendix 2](#)).

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- > continuity in medication management – APAC key performance indicators ([Appendix 3](#)).

## 4.3 Patient charges and business rules

Hospitals participating in pharmaceutical reforms are required to accept and implement the patient charges and business rules to maintain compliance with the PBS rules, consistency across the public sector and to maintain equity with the community sector.

### Supporting document

- > The patient charges and business rules are available as an appendix to this policy directive
- > patient charges and business rules for hospitals participating in the pharmaceutical reforms ([Appendix 4](#)).

## 5. Scope

This policy directive applies to:

- > All public hospitals participating in the pharmaceutical reforms initiative.

## 6. Responsibility

Participating hospitals are responsible for:

- > complying with the terms and conditions of the Pharmaceutical Reforms Agreement
- > reporting the achievement of the APAC milestones and APAC key performance indicators to SA Health
- > accepting and implementing the patient charges and business rules.

SA Health is responsible for:

- > reporting to the Special Access Programs Branch of the Department of Health and Ageing, Canberra through the pharmaceutical reforms team, Safety and Quality Unit, SA Health, and Intergovernment Relations Unit, SA Health.

## 7. Risks

Non-compliance with the conditions of the Pharmaceutical Reforms Agreement will revoke the hospital's entitlement to participate in the PBS Access Program and the Chemotherapy Pharmaceuticals Access Program.

Achievement of APAC milestones and key performance indicators is at risk if appropriate resources are not sustained.

South Australia has been allocated a ceiling for its public hospital PBS and CPAP expenditure. If the combined CPAP and PBS expenditure exceeds the ceiling, the state is responsible for 50 per cent of the expenditure above the ceiling.

A non-standardised approach to dispensing and charging under the PBS and CPAP programs will result in patient and staff confusion as well as lack of equity across the public sector.

The inability to recruit and sustain appropriate staff levels will impact negatively on the hospital's ability to achieve continuity in medication management.

## References

- <sup>1</sup>. APAC Guiding principles to achieve continuity in medication management available from:  
[http://www.health.gov.au/internet/main/publishing.nsf/Content/4182D79CFCB23CA2CA25738E001B94C2/\\$File/guiding.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/4182D79CFCB23CA2CA25738E001B94C2/$File/guiding.pdf)
- <sup>2</sup>. The Society of Hospital Pharmacists of Australia. Committee of Specialty Practice in Clinical Pharmacy. *SHPA Standards of Practice for Clinical Pharmacy*. J Pharm Pract Res 2005;35(2):122-46

## For more information

**SA Health**  
**Pharmaceutical Reforms**  
**Level 8 Citicentre Building**  
**11 Hindmarsh Square Adelaide 5000**  
**Telephone: 08 8226 7375 / 08 8226 7240**  
**[www.safetyandquality.sa.gov.au/pharmreforms](http://www.safetyandquality.sa.gov.au/pharmreforms)**

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## Appendix 4 – Survey sent to CHSA Hospitals

### Ensuring quality use of medicines in country SA Survey for Hospitals

#### Instructions for completing this survey

All respondents are to complete *Section 1 – Background Information*.

Responders answer to Section 1 question 6 (regarding the way that Pharmacy services are provided in your institution) will determine whether a response is needed in section 2, 3, 4, 5 **or** 6. Specifically, respondents who answer

- a) - **By the hospital within the hospital** should respond to **Section a** only
- b) - **Contracted pharmacist(s)** should respond to **Section b** only
- c) - **Community pharmacist(s)** should respond to **Section c** only
- d) - **Another hospital services located within the hospital** should respond to **Section d** only
- e) - **Other** should respond to **Section e** only

Please complete and return this survey to [penny.joyes@health.sa.gov.au](mailto:penny.joyes@health.sa.gov.au) by COB 2 April 2010. If you have any questions about this survey contact Kingsley Coulthard [kingsley.coulthard@health.sa.gov.au](mailto:kingsley.coulthard@health.sa.gov.au).

Background Information	
1. Contact name	
2. Contact phone number	
3. Contact email address	
4. Which hospital are you responding on behalf of?	
5. Which cluster are you part of?	
6. What is your position within the hospital?	
7. Who provides pharmacy services to your hospital?	
8. What is the nature and scope of the pharmacy services delivered (please tick all boxes that apply)?	<input type="checkbox"/> Procurement of pharmaceuticals <input type="checkbox"/> Dispensing <input type="checkbox"/> Clinical pharmacy services <input type="checkbox"/> Provision of information about pharmaceuticals <input type="checkbox"/> Manufacturing <input type="checkbox"/> Other (please specify below)
9. Do you believe the current level of service delivery is adequate? If, no, what other pharmacy services would you like to deliver and why are these not currently being delivered	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Do patients receive parenteral cytotoxics at your hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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### Section a - Pharmacy services delivered by the hospital, within the hospital

11. How many staff (including technicians, pharmacists and support staff) are employed to provide pharmacy services in your hospital?	
12. What is the organisational structure of this model? a. Briefly what are the roles and responsibilities of staff? (organisational charts may be attached in response to this question if required)	
13. What is the relationship between the hospital pharmacist and local community pharmacists?	
14. In your opinion, what are the strengths and weaknesses of this model (including staffing issues, service deliver issues etc)?	

### Section b - Pharmacy services provided within the hospital by contracted providers

15. Are staff employed by CHSA to support this model? If so: a. How many staff? b. What is the organisational structure? c. What are the roles and responsibilities of staff? If not, describe the staffing structure in place to support model.	
16. Which provider(s) are delivering pharmacy services?	
17. Who is responsible for arranging and managing contracts with providers?	
18. In your opinion what are the strengths and weaknesses of using contracted providers?	
19. What is the relationship between contracted providers and on site staff (eg. Nurses place order, the pharmacy delivers the drugs and nurses put the drugs in imprest)? a. Do medications come as imprest, webster packs (that nurses administer from) or as IPS? b. What clinical services are delivered as part of the contact (if any)? Eg. Does a pharmacist visit the hospital as part of the service?	

### Section c - Pharmacy services are provided by community pharmacists external to the hospital

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20. Are staff employed by CHSA to support this model? If so: a. How many staff? b. What is the organisational structure? c. What are the roles and responsibilities staff? If not, describe the staffing structure in place to support model.	
21. In your opinion, what are the strengths and weaknesses of this model?	
22. Is there a formal agreement in place for pharmacy service provision?	

### Section d - Pharmacy services are provided by another hospital, within the hospital

23. Are staff employed within your hospital by CHSA to support this model? If so: a. How many staff? b. What is the organisational structure? c. What are the roles and responsibilities of these staff? If not, describe the staffing structure in place to support model.	
24. In your opinion, what are the strengths and weaknesses of this model?	
25. What is the relationship between the hospital based pharmacist and local community pharmacists?	

### Section e - Pharmacy services are provided in another way

26. Please briefly explain the model that is in place (eg. Who provides what services and when etc)	
27. Are staff employed by CHSA to support this model? If so: a. How many staff? b. What is the organisational structure? c. What are the roles and responsibilities of staff? If not, describe the staffing structure in place to support model.	
28. In your opinion what are the strengths and weaknesses of this model?	

**Thank you for completing this survey**

Please complete and return this survey to [penny.joyes@health.sa.gov.au](mailto:penny.joyes@health.sa.gov.au) by COB 2 April 2010. If you have any questions about this survey contact Kingsley Coulthard [kingsley.coulthard@health.sa.gov.au](mailto:kingsley.coulthard@health.sa.gov.au).

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## Appendix 5 – Example of Questionnaire From Site Visits

Ensuring Quality Use of Medicines in Country SA

### Questions for Site Visits

<b>Date</b>	
<b>Location</b>	
<b>Note taker</b>	
<b>Person(s) interviewed</b>	

Question	Response
<b>General Questions</b>	
Are there aged care beds on the hospital site? If yes, how many aged care beds does the hospital have? How are aged care drugs supplied? Webster packs? Who supplies them?	
How many acute beds are there in the hospital? What is the average length of stay? What is the average occupancy rate of the hospital?	
How are pharmacy services delivered? (eg. By contracted provider, community pharmacist etc.) How often are services delivered?(eg. 1 day a week) How much does the service provider charge? Is there a formal contract in place? Are there KPIs in the contract? (eg. Minimum number of hours the provider will deliver services, which specific services will be provided etc)	
How many to Aboriginal patients visits the hospital?	

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Where Aboriginal populations are high, are there any specific issues that need to be considered in relation to pharmacy service delivery for this group?	
Are you aware that CHSA has a drug and therapeutics advisory committee? What is your interaction with this group? Do you feel they meet your needs?	
<b>Workforce and Infrastructure</b>	
Who in the hospital is involved in typical pharmacy services? Eg. Imprest checking by nurses Approximately how many FTE equivalents carry out this work?	
Infrastructure in place (Kingsley and Penny to note)	
<b>Access and equity/quality and safety for patients</b>	
What kind of services are delivered? (Explanation of APAC principles and PBS reform in metro so that comparisons can be drawn). <ul style="list-style-type: none"> <li>▪ Checking medication charts</li> <li>▪ Reviews of drugs ordered by the hospital</li> <li>▪ Checking expiry dates of medication</li> <li>▪ Continuing education for staff</li> <li>▪ Taking patient's drug history</li> </ul> Are you satisfied with the services being delivered?	
Do patients receive discharge counselling? If yes, from who? Is it written, verbal or both? Do hospital staff have access written information, such as E-MIMs, which can be printed for patients?	
How does the hospital get drugs on weekends and after hours?	
When a patient is transferred from a metropolitan hospital, what communication is in place to tell the country hospital which medications the patient is taking? Are patients given discharge medications? If a patient is transferred after hours/ on weekends, how do you ensure they have appropriate medications (given that local pharmacy may not be open).	

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<p>Are patients given medication on discharge? If no, what is the process for ensuring that patients get discharge drugs?</p>	
<p>Does this hospital have a renal dialysis unit? If yes, how many chairs are there? Where do the drugs for this come from? Are there any issues with drugs coming from metropolitan hospitals?</p>	
<p>What do you see as the key risks associated with the current level and method of pharmacy service delivery?</p>	
<p>What improvements would you like to see made to your current service delivery?</p>	
<p><b>Cytotoxics</b></p>	
<p>Are cytotoxics given at this hospital/site? If no, are they given elsewhere? Where are they given?</p>	
<p>Outline the process for the supply and administration of cytotoxics from when the patient leaves the metropolitan oncology service</p> <ol style="list-style-type: none"> <li>a. Is the protocol sent from metro and filed in patient records?</li> <li>b. Is there a separate prescription for each cycle to be administered when the patient returns home?</li> <li>c. Are there accredited cytotoxics staff?</li> <li>d. How are cytotoxics acquired and from who?</li> <li>e. How is it delivered?</li> <li>f. Who pay for the drugs?</li> <li>g. What information is supplied re: adjunct drugs (anti-nausea etc)</li> <li>h. Is there any role for pharmacy staff in the process apart from merely receiving the drug and ensuring appropriate storage?</li> <li>i. who currently accepts responsibility of ensuring that the drug and dose match the script or protocol and that the drug is given according to the relevant protocol</li> </ol>	
<p>What do you see as the major risks with the current process?</p> <ol style="list-style-type: none"> <li>a. Are there any case studies or incidents or near misses that illustrate issues with the current process?</li> </ol>	
<p>What do you believe would assist with ensuring the safe administration of cytotoxics?</p>	

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## Appendix 6 – Schedule of Site Visits

### Tue 20 April

8:00 – 9:00am Balaklava Hospital, meeting with Sandra Watson  
11:30 - 12:30pm Clare Hospital, meeting with Lesley Phillips  
2:00 – 3:00pm Gawler Hospital, meeting with Gerry Lloyd

### Wed 21 April

12:00 -1:00pm Murray Bridge Hospital, meeting with Karen Hollitt  
3:00 – 4:00pm Strathalbyn Hospital, meeting with Sandy Rennie  
*Note: A visit was also scheduled for Mt Barker, but was cancelled due to ill health*

### Thur 22 April

8:30-9:30am Mt Gambier Hospital, meeting with Catherine Hughes  
11:00-12:00pm Millicent Hospital, meeting with Ros Brown  
1:30-2:30pm Kingston SE Hospital, meeting with Ann Reddy

### Fri 23 April

8:30-9:30am Pt Lincoln Hospital, meeting with Sanday Le Brun  
10:30-11:30am Tumby Bay Hospital, meeting with Sandy Arancelovic  
1:30-2:30pm Cleve Hospital, meeting with Cathy Giersch

### Tue 27 April

8:00 – 9:00am Whyalla Hospital, meeting with Jim McMenemy  
9:00-9:30am Whyalla Hospital, meeting with Chris Thompson (Spencer Gulf Rural health School)  
11:30am- 12:30pm Pt Pirie Hospital, meeting with Liz Bice  
12:30-1:30pm Pt Pirie Hospital, meeting with Nes Lian-Lloyd  
2:30-3:30pm Pt Augusta Hospital, meeting with Tasma Wagner

### Fri 30 April

11am- 12pm Angaston Hospital, meeting with Trudi Morrissey

### Tue 11 May

2:00-3:00pm Teleconference with Berri Hospital, spoke to Sally Cameron and Micheal Morris

### Wed 12 May

2:00 – 3:00pm Teleconference with Wallaroo Hospital

# DRAFT – FOR CONSULTATION

## Appendix 7 Notes from Stakeholder Forum

### Ensuring Quality Use of Medicines in Country SA Stakeholder Forum

#### Context

Pharmacy services within hospitals are made up of two major components which are the traditional medication supply role and the provision of clinical pharmacy services. In essence the latter refers to the provision of services aimed at optimising the safe and effective use of medicines. This quality use of medicines has been demonstrated to improve patient outcomes including reduced readmissions and adverse outcomes. It was these positive outcomes that contributed to a decision by the Commonwealth Government to introduce a Pharmaceutical Reform process to public hospitals throughout Australia, which was aimed at improving clinical pharmacy services. The **CHSA Ensuring Quality Use of Medicines in Country SA** project is being undertaken in the context of this reform agenda to

- Evaluate the nature and extent of pharmacy service delivery to SA country hospitals
- Identify barriers to achieving quality use of medicines in country SA
- Make recommendations to improve pharmacy service delivery, with a particular emphasis on the quality use of medicines component of the Reform
- Evaluate the potential to introduce PBS to relevant country hospitals.

As part of the project consultation process, a forum was held on Thursday 29 April at Franklin Street Apartments, Adelaide.

Invitations were extended to a wide range of stakeholders, including SA Health staff contractors and peak bodies.

#### Attendees

The following people attended and contributed to the forum

Lindy Crawford	Director of Nursing, Port Augusta Hospital
Catherine Hughes	Chief Pharmacist, Mt Gambier Hospital
Frank May	Director, RGH Pharmacy Consulting Services
Vaughn Eaton	Director Pharmacy Services, Flinders medical Services
Liz Bice	Chief Pharmacist, Pt Pirie Hospital
Lee Sadler	MMR State Facilitator, Pharmacy Guild of Australia (SA Branch)
Sally Cameron	Director of Nursing, Berri Hospital
Kaye Barratt	Senior Project Officer, Pharmacy Reform
Steve Morris	Chief Pharmacist, SA Health
David Ng	Branch Director SA & NT, Pharmaceutical Society of Australia (SA Branch) Inc
Tasma Wagner	Chief Pharmacist, Pt Augusta Hospital
Tin Huynh	Partner/State Manager-SA, Hospital Pharmacy Services
Michele Robinson	Coordinator Quality Use of Medicines - Education and Training, Aboriginal Health Council of SA

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## Format

The forum was facilitated and was structured as a modified 'SWOT' analysis, looking at the strengths of current arrangements, areas where improvement is needed if country is to move towards meeting the APAC guidelines for Quality Use of Medicines, constraints to achieving these guidelines and suggestions of possible strategies.

## Strengths, weaknesses and threats

While services vary between sites and provision arrangements, it was identified that there were many strengths in existing services although due to the diversity of arrangements the strengths identified may exist in only a limited number of places. These include (depending on the site and local arrangements):

- Huge commitment & dedication of staff to community & services – hospital pharmacists, nurses, community pharmacists
- Flexibility of pharmacy services
- Good relationships and communication between hospital and Community Pharmacists & Prescribers
- The ability to provide good clinical reviews, inpatient education and / or discharge medication profiles
- Review and rotation of stock
- Education for staff
- Timely delivery of services
- Support for onsite services such as the renal unit
- The ability to provide medication reviews for aged care patients
- Support for Pharmacy Students who in turn can assist in quality activities such as audits
- Ability to support pre-registration Pharmacists at larger sites, which was considered to improve recruitment & retention potential
- The relatively small pharmacy departments & hospitals give ready access to senior management which assists in achieving change
- Good links with Aboriginal Health services, assisted by continuity and stability of pharmacy staff.
- For the Pharmacists, job satisfaction through diversity (broad scope of practice) and being appreciated by nursing staff and patients and team work with whole community
- Positive patient outcomes – Compliance and Relationship Building
- High community profile of Pharmacists
- Ability to see results and impact of interventions (accountability & satisfaction)
- Ability to provide patient material distribution (remotely) supported by onsite pharmacists (beyond site)

Other initiatives that were identified as positives in the provision of pharmacy services in country SA were:

- The Qumax program's ability to engage Aboriginal communities and get the quality use of medicines 'on the agenda' in communities
- Access to Pharmacy Guild grants

Areas for attention in working towards the APAC guidelines were identified as:

- Limited resources could be used more effectively if there was more standardisation. Examples include development of standing orders, policies and procedures. All providers require access to standard resources/protocols, etc.
- Improved consistency of resources allocation/ distribution between sites
- Increased access to:
  - Training
  - Resources including eMIMS/MIMS, ability to access online intranet resources from other regions, patient information data bases
- More efficient use of visiting pharmacist time/capacity and nursing staff time through better quality control/stock notation and ordering

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- Consideration of more onsite pharmacies to improve access to clinical pharmacy reviews and discharge education, accessibility of supply, support of doctors and nurses
- Increase administration and HR support to maximise clinical capacity of pharmacists
- Better use of the “GP Pharmacy Review” including more uptake by GPs, the ability for the discharging officer (if not a GP) to refer, improved methods of communication of findings to hospital staff
- Potential to decrease length of stay through better access to discharge medications out of normal working hours
- Ensuring that pre-admission (referral letter) information from GP software only includes current medication
- Improved communication in CHSA sites about the role of hospital pharmacists, including quality clinical interventions
- Attention to workforce issues including
  - Reduction of professional isolation through improvised access to clinical support/advice, and clinical supervision/mentorship
  - Increased access to training and development
  - Increased availability of senior staff
  - More structured processes for maintaining currency of clinical knowledge and skills
- Need for clear staffing and service models for CHSA e.g.: cluster/general hospital ‘hub’ with out reach ‘spokes’
- Extension of current pharmacy service arrangements to deliver 24/7 service
- Attention to legibility of medication charts including software consistency issues, use of electronic prescribing
- Inequitable access to public outpatient clinic access to medications in country when compared to metropolitan hospitals – different funding models result in country patients travelling to Adelaide to access PBS funded drugs, or outpatient medications being posted to patients resulting in additional costs and lack of access to education to patient at time of dispensing
- Inconsistency in pharmacy contracts. Need for KPIs related to APAC and Equip requirements.
- Expectations on pharmacists to take on additional responsibilities/tasks.
- Diversity in Oncology models in use

Constraints to achieving QUM in Country were identified as:

- Economy of scale – it is not viable to have onsite pharmacists at all sites
- In some locations lack of access to IT facilities, compatibility & lack of knowledge/skills in using these
- Recruitment & retention of pharmacists including
  - Comparative salary and conditions (with other States and the private sector)
  - Limited opportunities for exposure to CHSA (e.g. to host students)
  - Need for ‘critical mass’ in local team to achieve sustainability
- Ability to employ minimum staffing levels at each site
  - Knowing what minimum staffing levels are
- Tension between 24/7 service expectation vs. 5 day/week staffing models
- Peer recognition of skills and clinical competency of country hospital pharmacists and transferability of skills/experience to metropolitan sites – no career pathways for country pharmacists to move into metro roles, with a perception that working country leads to ‘deskilling’
- Staff capacity and opportunity to continue to develop clinical competency, specialist skills etc
  - Access to training
  - Clinical support & supervision accessibility
- Current inability to access PBS revenue to assist in implementation of QUM

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- Infrastructure, clinical space limitations
- Limited access to specialist pharmacists in rural areas – need a model to upskill local ‘generalists’
- Current ICT infrastructure to enable technology supported models of staff support, supervision, client consultations etc
- Diversity of providers
- Community Pharmacists Agreement - \$120m savings in Chemotherapy but retain community service obligations (equitable access to PBS).

### Potential Solutions

Issue	Solution
1. Funding - Staffing levels - OP - Contracts	<ul style="list-style-type: none"> <li>• Costing of pharmacy staffing model, (including consideration of additional support for community pharmacists) required to achieve compliance with APAC guidelines (existing sites and new)</li> <li>• Increase pharmacist staffing levels in established sites               <ul style="list-style-type: none"> <li>- include Technicians and pre-registered pharmacists</li> </ul> </li> <li>• Grow General Hospital Pharmacy Departments</li> <li>• Careful review of Pharmacy Budget Structures and other funding opportunities in CHSA and other site expenditure               <ul style="list-style-type: none"> <li>- reallocation of funds spent on medications by metropolitan hospitals for country patients to CHSA – or at least to sites with dispensing capability</li> </ul> </li> <li>• Investigate uncoupling of RAH renal drug funds to country sites with renal services</li> <li>• Improve contracts incorporating KPIs– work with local providers on opportunities to improve quality of services. Transparent tender process and evaluation of performance. ( SPU structure)</li> </ul>
2. Resources - IT - Space	<ul style="list-style-type: none"> <li>• iPharmacy roll out in CHSA</li> </ul>
3. Recruitment	<ul style="list-style-type: none"> <li>• Work with metropolitan pharmacists to identify applicants who may be interested in working in CHSA – flexible working arrangements</li> </ul>
4. Retention - Clinical Support - leadership - career structures - training	<ul style="list-style-type: none"> <li>• Clarify role and scope of SA Health Chief Pharmacist and team (focus on addressing aspects outside their scope)</li> <li>• Professional leadership role for CHSA</li> <li>• Establish pharmacy networks in clusters ( strengthen links between community pharmacists and contractors and CHSA employed pharmacists)</li> <li>• Mentor staff in role and in settling into the community (eg: sport)</li> <li>• Improve local clinical support/team stability</li> <li>• Market the unique opportunities in country roles</li> <li>• Ensure adequate cover for sick leave, on- call</li> <li>• <b>No</b> sole practitioners</li> </ul>
5. Service level & Quality	No strategies identified due to lack of time

# DRAFT – FOR CONSULTATION

## Appendix 8 – Schedule of Consultation with Stakeholders

### **8 February, 4:00-5:00pm – Rural Chief Pharmacists Meeting (teleconference)**

Attendees: Catherine Hughes (Chief Pharmacist, Mt Gambier), Steve Morris (Chief Pharmacist SA Health), Tasma Wagner (Chief Pharmacist, Pt Augusta), Liz Bice (Chief Pharmacist, Pt Pirie), Gilbert Yeap (Chief Pharmacist Whyalla) and Frank May (Director, RGH Pharmacy Consulting Services).

### **3 March, 1:00-2:00pm – Pharmacy and Palliative Care**

Meeting with Allison McLeod (Network Development Manager, Palliative Care Clinical Network)

### **3 March, 2:30-3:30pm – Country Health SA Oncology Review**

Meeting with Jacqui Adams (Director, Cancer Services Country Health SA)

### **9 March, 9:30-10:30am – Pharmacy Contracts**

Meeting with Suzanne Ratcliffe (Senior Procurement Consultant, SA Health) and John Staker (Manager, Procurement Support, SA Health)

### **23 March – 4 May, 7:30-8:00am**

Fortnight meetings with Steve Morris (Chief Pharmacist SA Health) and Kaye Barratt (Senior Project Officer – Pharmaceutical Reform SA Health)

### **19 April, 2:00-3:00pm- Renal Patient Pharmacy Pathways SubGroup Meeting**

Attendees: Chris Doecke (Director Pharmacy Services RAH), Angela Thiel (Principal Project Manager Clinical Planning & Governance) and Stephen McDonald (Clinical Director, Renal Services, Country Health SA)

### **29 April, 10am-3pm – Pharmacy Forum**

*Attendees:*

Lindy Crawford	Director of Nursing, Port Augusta Hospital
Catherine Hughes	Chief Pharmacist, Mt Gambier Hospital
Frank May	Director, RGH Pharmacy Consulting Services
Vaughn Eaton	Director Pharmacy Services, Flinders medical Services
Liz Bice	Chief Pharmacist, Pt Pirie Hospital
Lee Sadler	MMR State Facilitator, Pharmacy Guild of Australia (SA Branch)
Sally Cameron	Director of Nursing, Berri Hospital
Kaye Barratt	Senior Project Officer, Pharmacy Reform
Steve Morris	Chief Pharmacist, SA Health
David Ng	Branch Director SA & NT, Pharmaceutical Society of Australia (SA Branch) Inc
Tasma Wagner	Chief Pharmacist, Pt Augusta Hospital
Tin Huynh	Partner/State Manager-SA, Hospital Pharmacy Services
Michele Robinson	Coordinator, Quality Use of Medicines, Education and Training, Aboriginal Health Council of SA

### **10 May, 2:30-3:30pm – Follow-up meeting – Country Health SA Oncology Review**

Meeting with Steve Morris (Chief Pharmacist, SA Health) and Jacqui Adams

### **11 May, 10:30-11:30pm – Procurement of pharmacy services**

Meeting with Paul Smith (Manager Strategic Contracts, SA Health)

### **11 May, 12:30-1:30pm – Teleconference with other states re: rural pharmacy services**

Teleconference with representatives from Tasmania and Victoria Health Departments

# DRAFT – FOR CONSULTATION

## Appendix 9 – 2008 Analysis by SA Health Pharmaceutical Services and Strategy unit

Mt Gambier Hospital								
Clinical Service	Specialty	SHPA Category	SHPA Ratio	Number of Beds	SHPA FTE	Proposed FTE	Existing FTE	Variance
Surgery	Surgery	3	40	27	0.68	0.68	limited	-0.68
Medical	Medical/Pal care	2 / 4	35	21	0.60	0.60	limited	-0.60
Obs/Paediatrics	Obs/Paediatrics	2	50	20	0.40	0.40	limited	-0.40
High Dependency	High Dependency	5	20	6	0.30	0.30	limited	-0.30
Private	Medical/surgical	3/4	35	14	0.40	0.35	limited	-0.35
Emergency	Short stay ED	n/a	50	4	0.10	0.10	limited	-0.10
Day surgery	Day Surgery	2	50	15	0.30	0.30	limited	-0.30
<b>Totals</b>				<b>107</b>	<b>2.78</b>	<b>2.73</b>	limited	<b>-2.73</b>
<b>Av Beds/Pharm</b>				<b>39.19</b>				

Whyalla Hospital								
Clinical Service	Specialty	SHPA Category	SHPA Ratio	Number of Beds	SHPA FTE	Proposed FTE	Existing FTE	Variance
Surgery	Surgery	3	40	18	0.45	0.45	limited	-0.45
Medical	medical	4	30	26	0.87	0.87	limited	-0.87
Paediatrics	Paediatrics	3/4	35	5	0.14	0.14	limited	-0.14
High Dependency	High Dependency	5	20	8	0.40	0.40	limited	-0.40
Maternity/women's	Maternity/women's	2	50	14	0.28	0.28	limited	-0.28
Neonate	Neonate	5	20	3	0.10	0.10	limited	-0.10
Day surgery/ chemo	Day surgery/ chemo	2	50	22	0.44	0.44	limited	-0.44
<b>Totals</b>				<b>96</b>	<b>2.68</b>	<b>2.68</b>	limited	<b>-2.68</b>
				<b>35.83</b>				

Pt Augusta Hospital								
Clinical Service	Specialty	SHPA Category	SHPA Ratio	Number of Beds	SHPA FTE	Proposed FTE	Existing FTE	Variance
Medical	Medical	4	30	24	0.80	0.80	0.07	-0.73
Medical	Medical	4	30	18	0.60	0.60	0.07	-0.53
Surgical	Surgical	3	40	6	0.15	0.15	0.07	-0.08
Critical care	HD	5	20	5	0.25	0.25	0.07	-0.18
Gynae	Gynae	3	40	7	0.18	0.18	0.07	-0.11
Paediatrics	Paediatric	4	30	14	0.47	0.47	0.07	-0.40
Obstetrics	Obstetrics	2	50	6	0.12	0.12	0.07	-0.05
Neonate	High Dependency	5	20	2	0.10	0.10	0.07	-0.03
Day surgery	Day Surgery	2	50	10	0.20	0.20	0.07	-0.13
Specialist nephrology	Renal Dialysis	2	50	18	0.36	0.36	0.07	-0.29
<b>Totals</b>				<b>110</b>	<b>3.22</b>	<b>3.22</b>	<b>0.70</b>	<b>-2.52</b>
<b>Av beds/Pharm</b>				<b>34.14</b>				

# DRAFT – FOR CONSULTATION

Pt Pirie Hospital								
Clinical Service	Specialty	SHPA Category	SHPA Ratio	Number of Beds	SHPA FTE	Proposed FTE	Existing FTE	Variance
A Ward	Medical	4	30	30	1.00	1.00	limited	-1.00
A Ward	Mental Health	4	30	2	0.07	0.07	limited	-0.07
A Ward	HDU	5	20	3	0.15	0.15	limited	-0.15
C Ward	Obstetric	2	50	5	0.10	0.10	limited	-0.10
C Ward	Surgical	3	40	14	0.35	0.35	limited	-0.35
B Ward	Nursing Home	1	90	28	0.31	0.31	limited	-0.31
B Ward	Palliative Care	1	90	2	0.02	0.02	limited	-0.02
B Ward	Respite Care	1	90	2	0.02	0.02	limited	-0.02
Theatre	Day Surgery	2	50	6	0.12	0.12	limited	-0.12
Theatre	Chemotherapy	2	50	4	0.08	0.08	limited	-0.08
<b>Total</b>				<b>96</b>	<b>2.22</b>	<b>2.22</b>	<b>limited</b>	<b>-2.22</b>
<b>Av</b>								
<b>beds/Pharm</b>				<b>43.2</b>				

**Appendix 10 – Announcement regarding the establishment of SAMAC**



10/074, 18 June 2010

## **IMPROVING THE QUALITY USE OF MEDICINES IN SA**

I am pleased to announce the establishment of the South Australian Medicines Advisory Committee (SAMAC) which will be chaired by Emeritus Professor Lloyd Sansom.

SAMAC aims to contribute positively to the health of South Australians and to the performance of the health system by working to ensure the safe, clinically and cost-effective, appropriate and equitable use of medicines

SAMAC will:

- > Advise and support SA Health in the effective formulation of policy to address the many challenges regards to the governance and management of medicines.
- > Provide a resource for SA Health, South Australian hospitals, healthcare professionals and consumers on information and guidance relating to the equitable and quality use of medicines in South Australia.

SAMAC will operate as an expert committee of SA Health, reporting to Portfolio Executive through the Pharmaceutical Services and Strategy Branch of the Public Health and Clinical Coordination Division. It will be supported by a number of multidisciplinary expert standing committees and working groups to address specific medicines issues. These committees will provide stakeholders with opportunities for robust discussion, debate, and evaluation of medicines issues.

Health professionals will be asked to provide an expression of interest in relation to joining expert standing committees and will be selected based on their demonstrated interest and expertise.

For further information about SAMAC please visit <http://www.health.sa.gov.au/SAMAC>.

**DR TONY SHERBON**  
**Chief Executive**

**Appendix 11 – Media Release: New and enhanced regional cancer services in Whyalla and Regional South Australia**



**THE HON NICOLA ROXON MP**

**Minister for Health and Ageing**

**MEDIA RELEASE**

18 May 2010

**\$84.8 Million for New and Enhanced Regional Cancer Services in Whyalla and Regional South Australia**

The Rudd Government and the South Australian Government will invest a total of \$84.8 million to provide new and enhanced cancer facilities and equipment for Whyalla and regional South Australia, under the regional cancer centres initiative. This funding will deliver improved cancer services and outcomes for rural and regional patients.

With some cancers, patients from rural areas are up to three times more likely to die within five years of diagnosis than their counterparts in urban areas. The funding announced today for the 'Regional Cancer Services, South Australia' project will help improve cancer services and care for the more than 8,000 South Australian residents newly diagnosed with cancer each year.

Of the total funding for this project, the Rudd Government will provide \$54.3 million for the development of a new regional cancer centre in Whyalla, in addition to funding of \$15 million from the South Australian Government.

The investment of \$69.3 million for a new regional cancer centre at Whyalla will include:

- a day chemotherapy centre;
- in-patient and palliative care facilities;
- a Wellness Centre;
- educational and research facilities; and
- more accommodation for patients and staff.

The project will also include funding of \$2.48 million for the development of a digital tele-health network to create real time linkages between the Whyalla regional cancer centre, country general hospitals and metropolitan cancer service partners.

Importantly, the Whyalla regional cancer centre will form part of a state-wide network of 11 chemotherapy units across country SA, with funding of \$5.4 million towards the establishment of chemotherapy units in the 10 other rural and regional sites: Mt Barker, Mt Gambier, Port Augusta, Victor Harbor, Clare, Murray Bridge, Gawler, Northern Yorke Peninsula, Naracoorte and Port Lincoln.

The project is in addition to the Rudd Government's announcement of \$7.6 million to build a new bunker and provide an additional linear accelerator at Lyell McEwin Hospital in northern Adelaide. This expanded facility will provide radiotherapy services for rural and regional cancer patients, and will link to the new cancer centre to be developed at Whyalla.

## DRAFT – FOR CONSULTATION

The regional cancer centres initiative is part of the Government's plan to build a world-class cancer care system in Australia that will enable rural and regional Australians to have better access to essential cancer services, deal more effectively with cancer treatment challenges, and live longer with a better quality of life.

While Australia has better overall cancer survival rates than comparable countries, there is still unacceptable variation for some people, depending on the type of cancer, a person's socioeconomic status or where they live.

It is of great concern to the Government that for the 30 per cent of Australians living in rural and remote areas, outcomes are worse than for people living in the city.

The Whyalla Regional Cancer centre forms part of the Rudd Government's \$560 million commitment to establish a national network of best practice regional cancer centres so that Australians can get care closer to home and their community.

Since coming into office, the Government has committed over \$2.3 billion for cancer infrastructure, medicines, screening and research.

Today's announcement also shows the benefit of the Federal Government stepping up to the plate and providing funding for health services across Australia.

Under the National Health and Hospitals Network, the Rudd Government would provide 60 per cent of the funding for capital upgrades for public hospitals.

The Rudd Government's plan will see health services funded nationally and run locally through local hospital networks to deliver better outcomes for local communities.

**For all media inquiries, please contact the Minister's Office on 02 6277 7220.**