Submission No 15

INQUIRY INTO IMPACT OF AMBULANCE RAMPING AND ACCESS BLOCK ON THE OPERATION OF HOSPITAL EMERGENCY DEPARTMENTS IN NEW SOUTH WALES

Organisation: The Society of Hospital Pharmacists of Australia (SHPA)

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SHPA NSW Branch Committee response to Inquiry into Impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales (September 2022)

Introduction

The Society of Hospital Pharmacists of Australia (SHPA) is the national professional organisation for more than 6,100 hospital pharmacists, and their hospital pharmacy intern and technician colleagues working across Australia's hospitals and health system. SHPA is committed to facilitating the safe and effective use of medicines, which is the core business of pharmacists, especially in hospitals.

Challenges and pressures put on hospital services has been increasingly demanding with Emergency Departments in NSW dealing with over 3 million presentations at a rate of 35,376 per 100,000 population in 2020-2021.[1] With increasing Emergency Department presentations, the flow of patients through hospital must not only be efficient but must also consider patient safety in all aspects of a patient's journey. SHPA's Standards of Practice in Emergency Medicine Pharmacy Practice[2] outlines the key role of Emergency Medicine pharmacists in the pharmaceutical care required to facilitate safe and effective bed flow including conducting a Best Possible Medication History as well as prompt supply of medication.

SHPA welcomes the opportunity to provide feedback on the impact that ambulance ramping and access block is having on the operation of hospital emergency departments in New South Wales. This submission is provided on behalf of the SHPA NSW Branch Committee with input and expertise provided from members in SHPA's Emergency Medicine, Leadership and Management, Rural and Remote and Transitions of Care and Primary Care Specialty Practice groups.

Recommendations

1. NSW should become a signatory of the Pharmaceutical Reform Agreements (PRA) in order to provide sufficient medicines supply on discharge reducing reliance on primary care at Transitions of Care and prevent unnecessary Emergency Department presentations
2. All Emergency Departments should have dedicated seven-day Emergency Medicine clinical pharmacy services to facilitate prompt treatment and improve bed flow
3. Address the inadequate ratio of hospital pharmacists to hospital beds in regional and metropolitan NSW health services to support efficient bed flow, bed capacity and discharge turnaround times
4. Implement Partnered Pharmacist Medication Charting (PPMC) services to free up capacity of medical and nursing workforce, reduce length of stay, reduce medication errors and improve hospital capacity
5. Embed geriatric medicine pharmacists in aged care outreach services to prevent unnecessary hospital admissions from older Australians

The potential impact of these recommendations is demonstrated in the attached diagram (Appendix 1), further demonstrating how hospital pharmacist interventions can ease pressure on the various points along a patients journey through hospital. SHPA's recommendations are described in further detail below each Term of Reference (TOR).

Terms of Reference

TOR A: the causes of ambulance ramping, access block and emergency department delays;

There are multiple causes contributing to ambulance ramping and emergency department delays. The Australian College for Emergency Medicine position on access block[3] reports causes such as hospital beds at capacity, long outpatient waiting lists, aged care acute deteriorations as well as overloaded or inaccessible community-based services.

Coupled with this, indirect causes explored in SHPA's submission could include:

- Inadequate multidisciplinary care in geriatric outreach services
- Inequity across jurisdictions in access to medication post—discharge
- Inequity in clinical pharmacy services between regional and metropolitan NSW health services
- Delays in receiving medication due to pressures on medical and nursing workforce compounded by lack of Emergency Medicine pharmacists

TOR B: the effects that ambulance ramping and access block has on the ability and capacity of emergency departments to perform their function;

The pressure on Emergency Departments to move patients along results in inadequate assessment and thorough medication review which could be contributing to the emergency presentation.

TOR C: the impact that access to GPs and primary health care services has on emergency department presentations and delays;

Recommendation 1: NSW to become a signatory of the Pharmaceutical Reform Agreements (PRA) in order to improve medicines supply on discharge reducing reliance on primary care at Transitions of Care and prevent unnecessary Emergency Department presentations

Since the adoption of the Public Hospital Pharmaceutical Reforms in the signatory states and territories, the access of Pharmaceutical Benefits Scheme (PBS) medicines in public hospitals has been supported and enables approved public hospitals to prescribe and dispense PBS-subsidised medicines, chemotherapy drugs and highly specialised drugs to day-admitted patients and outpatients.

Patients being discharged from public hospitals in NSW are currently supplied 3-7 days' worth of discharge medicines, which contrasts with the other jurisdictions who are able to supply a months' worth of discharge medicines. Patients are then forced to see a GP within days of leaving hospital which can be challenging depending on where patients are geographically located.

As outlined in RACGP's *Health of the Nation 2020* report[4], in 75% of cases patients were able to see a GP within 24 hours. However, this reduced to 64% for patients in outer-regional, remote and very remote areas. This is reflected in the distribution of the GP workforce with 121 per 100,000 people GPs working in metro areas compared to just 69 per 100,000 people in very remote areas. Coupled with recovery following discharge from hospital and the pressures of the pandemic on GP practices, securing a timely appointment with a GP can be challenging. If patients cannot secure an appointment with their general practitioner to obtain further supplies of medication soon after discharge, many are forced to present to emergency departments.

The expansion of PBS into public hospitals has allowed more hospital pharmacists to be employed and provide clinical pharmacy activities to patients, as well as allow investment into specialised pharmacy services, such as pharmacists specialising in oncology, paediatrics, emergency medicine and geriatric medicine provided both to inpatients and outpatients also support this claim. These services are necessary to

safeguard and maximise the federal government's investment into new PBS medicines that treat complex conditions.

ACT Health has stated that they will work with the Commonwealth on a Public Hospital PRA for ACT public hospitals[5], therefore NSW Government's inaction in this area could result in it being the only jurisdiction In Australia not to have a PRA.

SHPA believes that the Commonwealth should make the PRAs a uniform policy in Australia and enter into a PRA with NSW. This would ensure a consistent standard of care for vulnerable patients who have just had a major health event requiring hospitalisation and reduces the need for individuals to immediately seek an appointment with their GP on discharge from hospital to continue receiving vital medicines.

TOR D: the impact that availability and access to aged care and disability services has on emergency department presentations and delays;

No comment.

TOR E: how ambulance ramping and access block impacts on patients, paramedics, emergency department and other hospital staff;

Ambulance ramping has reverberations beyond the Emergency Department and can affect all hospital staff involved in patient care. There has been an increased focus on the importance of psychosocial wellbeing for the healthcare workforce, including pharmacy, in the setting of the COVID-19 pandemic. This has been necessary because of the impact of stress on healthcare workers subsequent to the following factors:

- The risks faced by frontline workers including both exposure to infection and being subject to aggression by members of the public.
- Rapid and unpredictable changes in work practices.
- High demand for services and limited resources, including staffing. *Pharmacy Forecast Australia 2022* identifies wellbeing of hospital pharmacists as a key theme in the next five years, with one in five hospital pharmacy staff reporting that they will leave or substantially change their role due to pressures in the work environment.[6]

TOR F: the effectiveness of current measures being undertaken by NSW Health to address ambulance ramping, access block and emergency department delays;

No comment.

TOR G: drawing on other Australian and overseas jurisdictions, possible strategies, initiatives and actions that NSW Health should consider to address the impact of ambulance ramping, access block and emergency department delays;

Recommendation 2: All emergency departments should have dedicated Emergency Medicine clinical pharmacy services to facilitate prompt treatment and improve bed flow

A study into the accuracy of medication histories documented on GP referral letters showed 87% had one or more discrepancies in the patient's regular medications with 62% having one or more that were of moderate-high significance. Obtaining the Best Possible Medication History (BPMH) at admission is therefore critical in ensuring medication errors do not continue and contribute to the acute presentation.

A high proportion of these medication errors and associated harms can be prevented and intercepted by Emergency Medicine pharmacists at point of admission.[7] If medication-related presentations are identified promptly by Emergency Medicine pharmacists, they could also facilitate a swift discharge directly from the Emergency Department, preventing the need for the patient to be admitted and contribute further to access block. Furthermore, if there is risk of readmission identified a referral could be made by the Emergency

Medicine pharmacist to outreach services such as Hospital in The Home (HITH) or referral to a Transitions of Care pharmacist to prevent readmission.

A systematic review into the emerging areas of practice for Emergency Medicine pharmacists such as management of critically ill patients, Antimicrobial Stewardship roles and charting of regular medications were associated with positive patient outcomes.[8] There is also increasing involvement of Emergency Medicine pharmacists in the prompt management of sepsis and stroke through participation in response teams. Research has demonstrated that by adding an Emergency Medicine pharmacist to the acute stroke call-out team can provide an improvement in the average time to administer treatment to a patient by 12 minutes.[9] Emergency Medicine pharmacists therefore have a key role in contributing to timely access of medicines and medication safety in Emergency Department settings.

A 2019 survey of Australian hospitals showed one-third of hospitals with an Emergency Department did not have a dedicated clinical pharmacist while over two-thirds of EDs had no pharmacist present on weekends.[10] SHPA's Standards of Practice in Emergency Medicine Pharmacy Practice recommends that an Emergency Medicine Pharmacist service is provided seven days per week with 24-hour coverage per day.

SHPA's post hearing response to Questions on Notice from the 2020 Inquiry on health outcomes and access to health and hospital services in rural, regional, and remote New South Wales reported that the majority of the Principal Referral and Public Acute Group A hospitals did not have a hospital pharmacist on duty on 24-hours a day 7-days a week.[11]

A model of care implemented at The Sutherland Hospital in the South Eastern Sydney Local Health District, demonstrated that by increasing the FTE of Emergency Medicine pharmacists in the Emergency Department from 0 to 1 FTE weekday pharmacist, resulted in 40-50 Best Possible Medication Histories (BPMH) being taken per week. Additional interventions across the hospital increased from 128 per month to 282 per month.[12] To enhance the care of more patients in NSW hospitals, this model of care should be expanded across NSW.

Recommendation 3: Address the inadequate ratio of hospital pharmacists to hospital beds in regional and metropolitan NSW health services to support efficient bed flow, bed capacity and discharge turnaround times

Hospital pharmacists as medicines experts operatively manage and clinically ensure the safe and effective use of medicines within Australia's hospital system. There is a current and likely future shortage of suitably trained pharmacists with the capacity and the skills to deliver expert clinical pharmacy services within the NSW healthcare system, especially in regional and remote areas.

SHPA recommends investment in Hospital Pharmacist workforce recruitment and retention strategies, to build capacity to deliver care and to attract the best pharmacists across Australia to regional NSW hospitals. Beyond the capacity to deliver safe and quality care to NSW hospital patients, sufficiently staffed Hospital Pharmacy Departments will also have requisite capacity for research, innovation and collaboration, which are aims and values supported by NSW Health.

In 2021, SHPA NSW Branch recognised several NSW hospitals who were shortlisted for the NSW Branch Hospital Team Innovation Award, delivering innovative services such as virtual pharmacy services, using electronic software for chemotherapy dose-banding, reporting of allergies and adverse events as well as medication management services for patients under the Special Health Accommodation service.

The SHPA Standards of Practice for Clinical Pharmacy Services[13] recommends one Hospital Pharmacist to every 20 to 30 patients to ensure safe high-quality medicines management. The value of clinical pharmacy services is well documented in literature, with an Australian economic analysis indicating a $23 return for every $1 spent on clinical pharmacy services.[14] Below are just a few of the core clinical pharmacy services

described in the SHPA Standards of Practice for Clinical Pharmacy Services, which many NSW patients miss out on, risking the quality and safety of their care, due to inadequate investment for Hospital Pharmacists.

- taking medication histories and ensuring medications are charted correctly on admission and administered in a timely manner
- regular review of the safety, quality, storage and supply of medications during hospital stay
- review of discharge prescriptions, dispensing sufficient supplies of medications to take home, counselling patients on their medications and communicating changes to primary healthcare providers
- ensuring appropriate follow-up and monitoring of medications post-discharge including in specialised clinics and outpatient services and checking for adverse reactions to medications

Regional NSW hospitals are unable to meet these Standards with current funding levels for pharmacists. In comparison, Victoria, which despite having 25% less hospital inpatient beds, has 25% more hospital pharmacists than NSW, and is much closer to achieving these standards. According to the Productivity Commission, in 2017-2018, NSW hospital patients were 48% more likely to experience an adverse effect from medicines than Victorian hospital patients, and 29% more likely to experience an adverse effect from medicines than Queensland hospital patients.

SHPA therefore recommends that the NSW Government increases funding and Hospital Pharmacist positions in all regional NSW public hospitals to meet staffing ratios in SHPA Standards of Practice for Clinical Pharmacy Services.

Recommendation 4: Implement Partnered Pharmacist Medication Charting (PPMC) services to free up capacity of medical and nursing workforce, reduce length of stay and improve hospital capacity

In the current health system climate, there are known pressures throughout the hospitals and healthcare system with unprecedented demands on resources. The hospital admission process in emergency departments can often be a barrier to efficient bed flow, with the need to undertake a patient's medication history and chart their medicines being a task that doctors must juggle and balance along with their other responsibilities. Pharmacists are able to take more accurate medication histories in a timelier manner than their nursing and medical colleagues in hospitals, and when supported to chart these medicines via a PPMC model, can contribute to efficiencies in medication charting, timely supply and administration whilst also freeing up capacity for nurses and doctors to spend more time with patients.

Hospital Pharmacists already supervise and train junior doctors in prescribing and advise senior medical staff on medicine and treatment selection, dosing, medicine administration requirements and monitoring of adverse effects. PPMC has already been implemented in Victoria, Queensland and Western Australia. In a PPMC model, a pharmacist conducts a medication history interview with a patient; develops a medication plan in partnership with the medical team, patient, and the treating doctor. The pharmacist then charts the patient's regular medications with the doctor's authorisation, and the doctor charts any new medications that are initiated in hospital. Using a PPMC model will decrease the burden upon medical staff and clinical resourcing dedicated to medication charting and increase the through put of patients if medications are already reviewed and charted prior to admission and ready for review by the admitting medical or surgical team. This model has also been shown to improve medication safety and patient care.

A Deakin University health economic evaluation[15] of more than 8,500 patients has explored the impacts of PPMC models upon patients in emergency departments and general medicine wards. The economic evaluation also showed a decrease in the proportion of patients with at least one medication error from 19.2% to 0.5% and a reduction in patient length of stay from 6.5 days to 5.8 days. The estimated savings per PPMC admission was $726, which in the replication was a total hospital cost saving of $1.9 million with the five health services involved in the PPMC service continuing their operations.

Recommendation 5: Embed geriatric medicine pharmacists in aged care outreach services to prevent unnecessary hospital admissions from older Australians

Although only making up 16% of the population, older Australians accounted for 21% of all emergency department presentations in 2021-2022.[16] It is estimated that up to 30% of all hospital admissions of older people are medication-related, and approximately half of these are preventable.[17]

Embedding Geriatric Medicine pharmacists into broader hospital-based multidisciplinary aged care outreach services can provide better care for older people by supporting high-risk transitions of care and addresses access block by facilitating exit from, or preventing entry to, hospitals.

As noted in the Royal Commission into Aged Care Quality and Safety: Final Report[18], nowhere is the need for multidisciplinary services more apparent than at the interface between the hospital system and the aged care system. These services are typically hospital-led and, as highlighted in this report, these multidisciplinary teams must include pharmacists. Geriatric Medicine Pharmacists working in collaboration with doctors and nurses, can promptly respond to older people at risk of hospital admission and deliver appropriate care to manage the individual in their place of residence. This service provides better care for the older person whilst placing less strain on hospital emergency departments.

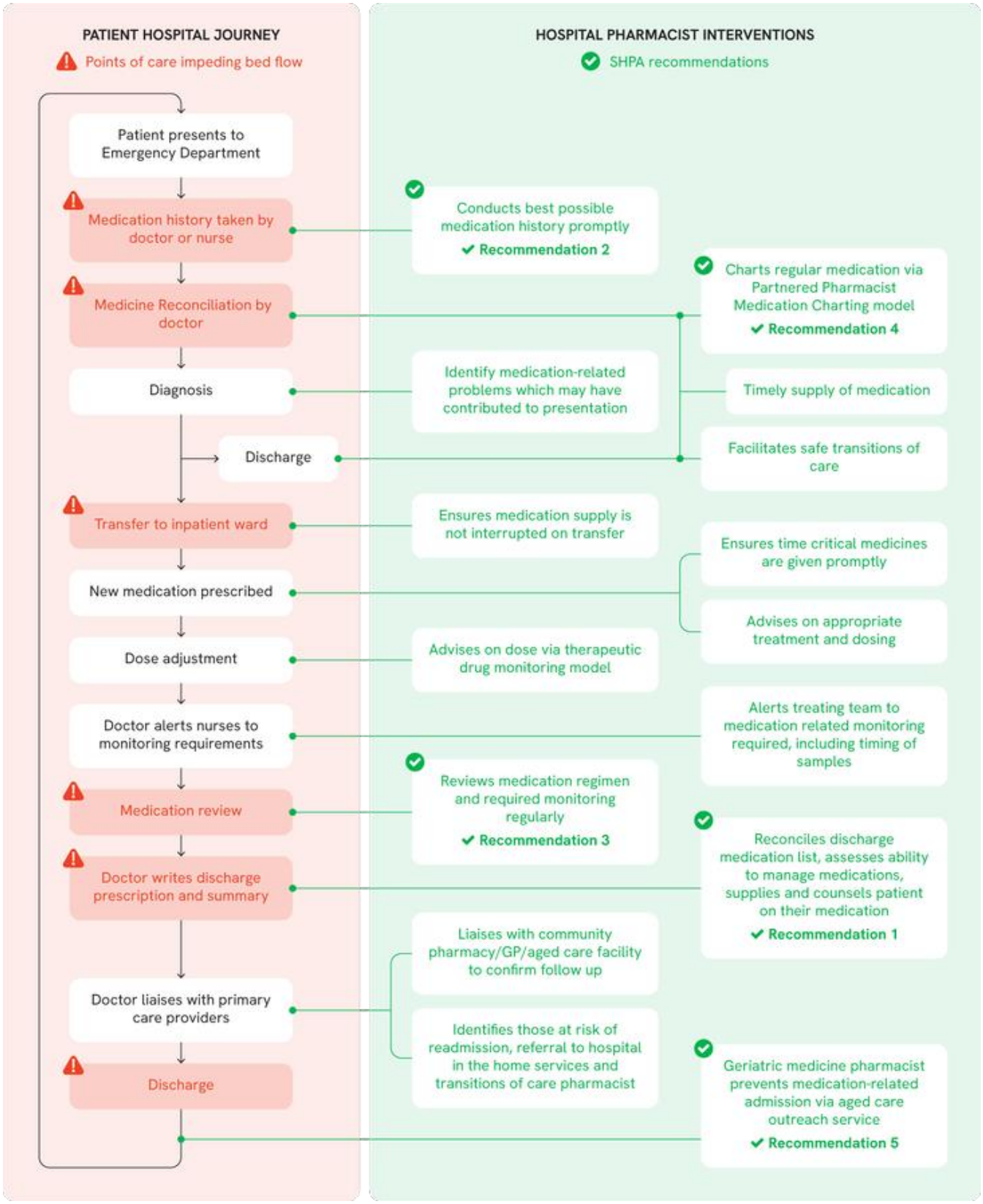
A major risk in the transition of care process is the misalignment of hospital and community services post-discharge. This leaves a gap for patients at a critical time leaving them at risk of medication error or mismanagement and a delay in medication supply, heavily compromising medication safety. If transitions of care are not undertaken properly, patients are at high-risk of readmission to hospital.

Following an inpatient admission, discrepancies in the discharge summary can occur, with the potential for these discrepancies being continued along each step in the transitions of care. An audit at an Australian regional hospital demonstrated that almost half of these discrepancies are attributed to regular medications being omitted.[19] 29% of these had moderate potential clinical significance reiterating that improved communication around changes to medication regimes at transitions of care is essential in preventing harm to older people.

TOR H: any other related matters.

No comment.

Appendix 1: Hospital pharmacist interventions to ease pressures on the various points along a patients journey through hospital



References

[1] NSW Ministry of Health. (2021). HealthStatsNSW. NSW Emergency Department Records for Epidemiology (SAPHaRI). Centre for Epidemiology and Evidence, Emergency Department Presentations. Available at: https://www.healthstats.nsw.gov.au/#/indicator?name=-unplanned-ed&location=NSW&view=Trend&measure=DSTRate&groups=Sex&compare=Sex&filter=Sex,Persons

[2] Welch, S., Currey, E., Doran, E., Harding, A., Roman, C., Taylor, S., Thomas, A. and Munro, C. (2019), Standard of practice in emergency medicine for pharmacy services. Journal of Pharmacy Practice and Research, 49: 570-584. https://doi.org/10.1002/jppr.1627

[3] The Australian College for Emergency Medicine. Position on Access Block. Available at: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block

[4] RACGP Health of the Nation Report 2020. Available at: https://www.racgp.org.au/getmedia/c2c12dae-21ed-445f-8e50-530305b0520a/Health-of-the-Nation-2020-WEB.pdf.aspx

[5] ACT Government. ACT Health Plan 2022-2030. Available at: https://health.act.gov.au/sites/default/files/2022-08/ACT%20Health%20Services%20Plan_2022%20to%202030_Accessible.pdf

[6]The Society of Hospital Pharmacists of Australia. Pharmacy Forecast Australia. (2022).Available at: https://shpa.org.au/publicassets/36f9b509-04fc-ec11-9106-00505696223b/Pharmacy%20Forecast%20Australia%202022%20Full%20Report.pdf?4d171d0a-84fd-ec11-9106-00505696223b

[7] Patanwala, A.E., Hays, D.P., Sanders, A.B., Erstad, B.L. (2011), Severity and probability of harm of medication errors intercepted by an emergency department pharmacist. International Journal of Pharmacy Practice, 19: 358-362. https://doi.org/10.1111/j.2042-7174.2011.00122.x

[8] Roman C.P., Dooley M.J., Mitra B. (2018). Roles of the emergency medicine pharmacist: A systematic review, American Journal of Health-System Pharmacy; 75,11: 796–806, https://doi.org/10.2146/ajhp170321

[9] Monash University. (2021). Acute stroke treatment improved by adding emergency pharmacist to the team. Available at: https://www.monash.edu/medicine/news/latest/2021-articles/acute-stroke-treatment-improved-by-adding-emergency-pharmacist-to-the-team

[10] Roman C.P., Dooley M.J., Mitra B. (2019). Emergency medicine pharmacy practice in Australia: a National survey. Journal of Pharmacy Practice and Research; 49: 439– 46. https://doi.org/10.1002/jppr.1546

[11] NSW Government. (2021). SHPA Post-hearing Response to Questions on Notice from Health outcomes and access to health and hospital services in rural, regional and remote New South Wales. Available at: https://www.parliament.nsw.gov.au/lcdocs/other/16573/4.%20AQON%20-%20Kristin%20Michaels%20and%20Jerry%20Yik%20-%20received%2018%20October%202021.pdf

[12] Webb, M., O'Connor, C. (2019). Improving medication safety in facilities through a collaborative 'Medication Safety Models of Care' working group. Available at: https://www.researchgate.net/publication/337826567_Improving_medication_safety_in_facilities_through_a_collaborative_%27Medication_Safety_Models_of_Care%27_working_group

[13] SHPA Committee of Specialty Practice in Clinical Pharmacy. (2013). SHPA Standards of Practice for Clinical Pharmacy Services. Journal of Pharmacy Practice and Research, 43(No. 2 Supplement), S1-69

[14] Dooley, M. J., Allen, K. M., Doecke, C. J., Galbraith, K. J., Taylor, G. R., Bright, J., & Carey, D. L. (2004). A prospective multicentre study of pharmacist-initiated changes to drug therapy and patient management in acute care government funded hospitals. British Journal of Clinical Pharmacology, 57(4), 513-521. doi:10.1046/j.1365- 2125.2003.02029

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

[16] Australian Institute of Health and Welfare. (2021). Emergency Department Care. Available at: https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care

[17] Roughead E.E., Semple S.J. (2009). Medication safety in acute care in Australia: Where are we now? Part 1: a review of the extent and causes of medication problems 2002–2008. Australia and New Zealand Health Policy; 6: 18.

[18] Australian Government. Royal Commission into Aged Care Quality and Safety. (2021). Final Report: Care, Dignity and Respect. Volume 1 Summary and recommendations.

[19] Wilkin, M. E., Knight, A. T., & Boyce, L. E. (2018). An audit of medication information in electronic discharge summaries for older patients discharged from medical wards at a regional hospital. Journal of Pharmacy Practice and Research, 48(1), 76-79. doi:10.1002/jppr.1340