When I was first asked about the possibility of working with Elsevier on an Australian adaptation of the Clinical Skills for Pharmacists textbook, my initial reaction was enthusiastic support. But I knew nothing about Australian pharmacy practice and was not sure if the text was relevant for Australian pharmacy students and pharmacists. Fortunately, the Australian co-authors, Greg Kyle and Marnie Firipis, have a wealth of experience and knowledge. Greg and Marnie carefully identified and replaced US-specific content with Australian-specific content while leaving the patient-care focus and core content intact.

The text has been reviewed and modified to suit the Australian context. This includes changing from American laboratory units to SI units, modifying spelling differences and ensuring the clinical context reflects an Australian practice environment.

Significant changes include a major rewrite of Chapter 1, The Practice of Clinical Pharmacy, and the creation of an entirely new chapter, Pharmacy Models of Care. Chapter 4, Pharmacy Models of Care, is entirely new to the Australian edition. It describes the major areas of pharmacy practice in Australia (hospital, community pharmacy and consultant pharmacy) and identifies emerging areas of practice (e.g. disease state management, immunisation, prescribing). To better emphasise the importance of the content, the Ethics in Pharmacy and Healthcare chapter was moved from Chapter 10 to Chapter 2, immediately following the introductory Chapter 1, Practice of Clinical Pharmacy.

I now know that pharmacists in the United States and Australia have much in common. Although the direction each country is taking as each envisions and shapes the practice of pharmacy are somewhat different, it is clear that we share a passion for patient care and for advancing our profession.

Karen J Tietze
Clinical skills are integral to the practice of pharmacy. They are the basis of and underpin all aspects of pharmacy practice. Pharmacists work in many and diverse areas. However, whether that work is in a hospital or community pharmacy, as a consultant, as a teacher or medical writer, or in a role involving clinical trials, product registration or reimbursement of medicines, or in some other area, pharmacists always work for patients and to improve health outcomes.

When asked to be co-authors of the Australian version of Karen Tietze’s book *Clinical Skills for Pharmacists*, we were thrilled and honoured. Karen has invested much into this book, now in its third edition. Pharmacy practice in Australia is different from other parts of the world, including the US; however, adapting this book to an Australian context allows scope for pharmacists to increase their skill set and hopefully start to drive practice change.

Some of the chapters may not seem relevant to Australian pharmacy practice, such as Chapter 6 *Physical Assessment Skills*. Indeed, some reviewers made this exact comment; however, pharmacists need to be aware of these techniques for their current practice, and there is no reason why pharmacists’ scope of practice cannot include some basic physical assessment in the foreseeable future – especially in the context of vaccination and prescribing. Other chapters – *Laboratory and Diagnostic Tests* and *Therapeutic Planning and Researching and Providing Drug Therapies* – may also be seen as ‘specialised’ areas of practice. However, it is our firm belief that pharmacy in Australia must evolve to embrace these areas as routine practice or they will be subsumed by other professional groups.

*Ethics* and communication are key skills that are also covered. A good understanding of these foundational topics will ensure that pharmacists are well equipped to handle most clinical situations. As the roles for pharmacists in Australia diverge and as pharmacists expand into new clinical territory, we believe that pharmacists with well-developed clinical skills will be increasingly valued. We trust this book will help pharmacists to be a part of driving practice change in Australia.

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<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The practice of Clinical Pharmacy</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Ethics in Pharmacy and Health Care</td>
<td>11</td>
</tr>
<tr>
<td>3</td>
<td>Communication Skills for Pharmacists</td>
<td>39</td>
</tr>
<tr>
<td>4</td>
<td>Pharmacy Models of Care</td>
<td>60</td>
</tr>
<tr>
<td>5</td>
<td>Taking Medication Histories</td>
<td>73</td>
</tr>
<tr>
<td>6</td>
<td>Physical Assessment Skills</td>
<td>94</td>
</tr>
<tr>
<td>7</td>
<td>Review of Laboratory and Diagnostic Tests</td>
<td>150</td>
</tr>
<tr>
<td>8</td>
<td>Patient Case Presentations</td>
<td>207</td>
</tr>
<tr>
<td>9</td>
<td>Therapeutics Planning</td>
<td>220</td>
</tr>
<tr>
<td>10</td>
<td>Monitoring Drug Therapies</td>
<td>238</td>
</tr>
<tr>
<td>11</td>
<td>Researching and Providing Drug Information</td>
<td>251</td>
</tr>
<tr>
<td></td>
<td>Appendix: Abbreviations by Chapter</td>
<td>268</td>
</tr>
<tr>
<td></td>
<td>Index</td>
<td>275</td>
</tr>
</tbody>
</table>
Chapter 4

PHARMACY MODELS OF CARE

LEARNING OBJECTIVES

- Name the major areas of pharmacy practice in Australia.
- Identify the differences between practice areas.
- Describe the primary components of practice in each area.
- Describe the role of the major representative organisations in developing pharmacy practice.

The Australian healthcare system is based around the Commonwealth Government as the national universal health insurer. However, the overall system is a mixture of private providers and publicly funded services (Figure 4.1). The majority of private services can attract a government rebate, so it is primarily a mixed public-private model. The Pharmaceutical Benefits Scheme (PBS) is the pharmaceutical arm of this insurance and aims to provide affordable access to essential medicines for Australians.

PHARMACY PRACTICE IN THE HEALTHCARE SYSTEM

Within the healthcare system, pharmacy practice can be largely divided into hospital practice, community practice and consultant practice, with some other emerging areas of practice (Table 4.1). There are a variety of organisations that represent pharmacists in these various practice areas, some specialised into a specific niche and others with a broader membership:

- Pharmaceutical Society of Australia (PSA) – the peak national professional organisation representing Australian pharmacists working in all areas of pharmacy practice in Australia and overseas.
- Society of Hospital Pharmacists of Australia (SHPA) – the professional body with a primary constituency in hospital practice but now expanding to represent pharmacists, pharmacy technicians and pharmacy associates practising in all areas of the Australian health system.
- Pharmacy Guild of Australia (PGA) – the registered employers’ organisation representing owners of approximately 5000 community pharmacies across Australia.
- Australian Association of Consultant Pharmacy (AACP) – jointly owned by the PSA and the PGA to promote and seek recognition for consultant pharmacy and other professional pharmacy services in Australia that add value to health.

Hospital Pharmacy Practice

Australian hospitals are either public (run by a state or territory government with funding from the Commonwealth) or private. Both types of hospitals are spread throughout the country, with smaller centres tending to only have a public hospital based on the philosophy of universal healthcare for all Australians (Figure 4.2). Private hospitals tend to be more focused in the services they offer – generally surgical, specialist medical, oncology and obstetrics.

The main difference between the public and private hospital models is the financial focus. Public hospitals are government run and, because governments demand more value for money and budget constraint, the focus is on cost minimisation. Consequently pharmacy and pharmacists work within an environment of constrained expenditure that emphasises costs. Private hospitals, however, are run on a profit model and while cost constraint is also an integral part of this model, the focus is generally on the differential between cost and charged price to...
**Figure 4.1** Funding of the Australian health system. Source: Australian Institute of Health and Welfare 2012

**Figure 4.2a** Princess Alexandra Hospital, Brisbane (major teaching hospital)

**Figure 4.2b** Millmerran Hospital (rural hospital). Source: Queensland Health 2014
Box 4.1 Typical Pharmacist Tasks during a Ward Round

- Provide drug information
- Suggest appropriate therapeutic options
- Advise on drug availability in the hospital, including any formulary restrictions
- Appropriate monitoring parameters for drugs
- Compatibility of multiple parenteral drugs
- Routes of administration (availability of doseforms, absorption, etc.)

Box 4.2 Preparing a Patient for Discharge

- Commence discharge planning on day 1 of admission
- Provide daily counselling to patients (or carers) to allow time for processing of information and questions
- Involve family members
- Consider the home environment such as living alone, the availability of a carer, dosing frequency and swallowing issues
- Liaison with a community pharmacy – dose administration aids
- Liaison with a general practitioner (GP) – post-discharge Home Medicines Review (HMR)
- Liaison with an aged care facility (if necessary)

generate the best outcome for the business running the hospital. Some hospitals run in a ‘hybrid’ mode where a private hospital has a contract with the relevant state government to provide public hospital services.

Pharmacists work in almost all private hospitals and larger public hospitals. Private hospital medications are funded through the PBS, through casemix funding via private health insurers or fully paid by patients. Public hospitals fund inpatient and non-PBS medications through state funding and the majority of states now access hospital PBS funding for outpatient and discharge medications. Many states have a visiting pharmacist program for smaller public hospitals that are deemed not large enough to warrant a pharmacist in their own right. These visiting pharmacists provide pharmacy services from the nearest larger regional hospital or sometimes from a local community pharmacy on a contract or sessional payment arrangement.

The pharmacy focus in hospitals generally follows the medical focus and can be divided into acute care, chronic care and dispensing. The majority of hospital admissions are due to an acute episode – whether an acute injury or illness or an acute worsening of a chronic condition. The role of pharmacists continues to evolve and the majority of a clinical pharmacist’s time in a hospital is consumed with medication reconciliation (validating pre-hospital medications), ward rounds with the medical team (Box 4.1) and preparing patients for discharge (Box 4.2). The Australian Council for Safety and Quality in Healthcare has produced a national recommendation for a medication reconciliation form (see Figure 4.3 on page 64). This has been adopted but may be modified by individual states.

The complex skill set required in a hospital environment is to integrate these tasks for a variety of patients. Simple cases of younger patients on no regular medications being admitted for surgery do not occupy a large
proportion of a pharmacist’s time. The majority of cases, however, are either a surgical and/or medical intervention in the background of one or more chronic medical conditions and multiple pharmaceutical treatments. These cases involve pharmacists to ensure the medication regimen is appropriate for the condition(s) being treated and also in the context of the patient’s underlying condition(s) and medications.

A major difficulty with hospital practice is that the patient is usually seen for a short snapshot of care and this provides little opportunity to have a significant impact on long-term care. Within this short timeframe, many changes can be made and these need to be explained to the patient by the medical and pharmacy team. Discharge planning starts on admission and the patient is kept abreast of changes made and the plan for any medication changes on discharge to minimise the confusion of an apparent (to the patient) sudden change in medications. The SHPA recommends the use of a Medication action plan (MAP) in its practice standards. The components of a MAP are listed in Box 4.3.

Box 4.3 SHPA-Recommended Clinical Activities that Contribute to the Components of a Medication Action Plan

1. Accurate medication history
2. Assessment of current medication management
3. Clinical review
4. Decision to prescribe a medicine
5. Therapeutic drug monitoring
6. Participation in multidisciplinary ward rounds and meetings
7. Provision of medicines information to healthcare professionals
8. Provision of medicines information to patients
9. Information for ongoing care
10. Adverse drug reaction management

Source: SHPA Committee of Specialty Practice in Clinical Pharmacy 2005

Items 1–3 in the MAP cover the process of medication reconciliation. The decision to prescribe step is undertaken by an authorised prescriber (medical practitioner, nurse practitioner, dentist, etc.) and may be on the recommendation of a pharmacist. Therapeutic drug monitoring includes pharmacokinetic (blood level, e.g. gentamicin, cyclosporin) and pharmacodynamic (clinical effect, e.g. international normalised ratio (INR), blood pressure) monitoring and tailoring therapy for the individual patient. Steps 7–9 involve drug information for various audiences. While the base information will be identical, the context and audience for the information will determine the level and language used (see Chapters 3 and 11).

Adverse drug reaction management, from a pharmacist perspective, includes: identifying potential signs and symptoms; management and treatment; providing alternative therapeutic options; and reporting to the Advisory Committee on the Safety of Medicines. In Australia, adverse drug reaction reporting is voluntary; however, all health practitioners are encouraged to report any actual or suspected adverse drug reaction.

The clinical role of a hospital pharmacist is focused on the snapshot of care, as is the role of the entire healthcare team. The components of the role comprise:

- detective (to determine the pre-hospital medication regimen and verify such from a variety of sources)
- advisor (to the medical team)
- overseer (to minimise the chances of medication errors or misadventure)
- counsellor (to ensure the patient is informed about changes).

The SHPA standards encourage pharmacists to document their activities in the medication chart or patient notes, as appropriate. Pharmacists are registered healthcare professionals and as such should document their episodes of care like any other healthcare professional.

Recent changes in hospitals (public and private) involve positioning a pharmacist in emergency departments to smooth the admission and assessment process. The predominant role is to take patient medication histories and document this information on the appropriate chart. This has been found to provide a more accurate
Figure 4.3  Australian Commission for Safety and Quality in Healthcare national template for medication reconciliation (Medication management plan). Source: Australian Commission on Safety and Quality in Health Care 2014.¹
medication history than is obtained by medical or nursing staff and is cost-effective at providing detailed and often time-critical information.4–7

However, emergency departments provide a 24-hour service, with the majority of cases arriving outside the standard pharmacy work hours of 8 am to 5 pm. The emergency role is normally staffed during office hours, sometimes with limited extended hours. Pharmacists should be employed on a 24-hour, seven-day roster to provide cover in areas of need such as the emergency department and other acute care wards. Pharmacist care is not only required during office hours.

The other main task of pharmacists in hospitals is dispensing. When not involved in ward clinical duties, pharmacists rotate through the dispensary providing assistance to the baseline rostered staff processing inpatient and outpatient prescriptions and providing discharge and medications.

Hospital pharmacists document a small part of their work on inpatient medication charts. The Australian National Inpatient Medication Chart has a space under each medication for a pharmacist comment. It also contains a dedicated space for documenting warfarin education (for relevant patients). There are also a variety of other documents used such as the Medication management plan (Figure 4.3). However, hospital pharmacists inconsistently document their discussions with the medical team, interventions or recommendations in the patient notes. This is another area where clinical practice should mirror that of other healthcare professionals to ensure pharmacist interventions are completely documented.

Community Pharmacy
Community pharmacies in Australia are privately owned businesses that provide the backbone of pharmacy services to the community. At the time of publication, pharmacies must be majority owned by a registered pharmacist (or multiple registered pharmacists) if owned through a company structure or, alternatively, by an individual pharmacist (sole trader) or a partnership of pharmacists. State pharmacy Acts limit the number of pharmacies in which any individual pharmacist may have a financial interest and the maximum can vary by state to minimise market monopolies. The vast majority of community pharmacies provide public access to subsidised medicines through the PBS.

The PBS tightly controls the prices for any medication listed thereon and provides pharmacies certainty of payment for the balance of the price of a medication after the patient co-payment. Its aim is to ensure that essential medications are affordable for Australians and it has two payment tiers, the concessional one being accessed through a range of entitlement cards issued by the Commonwealth Government (Figure 4.4). General PBS benefits are restricted to Australian citizens (proof is a Medicare card) or visitors from countries with which Australia has a reciprocal healthcare agreement. There is also a cap on concession and non-concession co-payments to ensure medicines remain affordable for the population. The maximum co-payments for concession (including veterans) and general beneficiaries are indexed each calendar year and are usually announced in late December. Once patients (or families) reach their relevant safety net maximum co-payment expenditure, they receive the relevant safety net card (Figure 4.5). Safety net entitlement cards are issued when concessional beneficiaries reach their expenditure limit and entitle the person (and their family) to receive free PBS medicines (excluding additional fees). General (non-concessional) patients receive a safety net concession card and receive PBS medicines for the same price as a concession card holder.

The first agreement negotiated between the PGA and the Commonwealth Government commenced in 1990.13 This and subsequent agreements set community pharmacy remuneration for dispensing PBS medicines and location rules for community pharmacies; recent agreements have included modest funding for developing professional services within the constraint of a community pharmacy model.

In addition to PBS dispensing, community pharmacies also provide other dispensing services (known as private prescriptions because there is no PBS subsidy), non-prescription medicine sales of scheduled (pharmacy-only and pharmacist-only) and ‘unscheduled’ medicines and a variety of other retail activities such as complementary medicines, baby needs, cosmetics and wound care.
Figure 4.4a Australian concession cards for PBS benefits. Source: Department of Human Services 2014†

This confluence of professional services in a retail environment can place community pharmacists in an ethical dilemma of profit versus care.

The differences in the clinical roles of a community pharmacist compared with a hospital pharmacist can be likened to the difference in medical care between a GP and a specialist. A community pharmacist (or GP) will usually see a patient regularly, develop a relationship with the person and provide ongoing care. A hospital pharmacist (or medical specialist) will usually only see a patient sporadically and only see snapshots or provide discrete episodes of care, with ongoing management deferred back to the community pharmacist (or GP).

Consequently, the clinical role of a community pharmacist is more than simply being a provider of medicines and products; it is to integrate the use of a variety of medicinal and other products within the context of the patient’s care to generate the best possible healthcare outcome for and within a variety of often complex chronic conditions. This can include:

- ongoing and new or short-term medications
- acute and/or chronic non-prescription medications
- complementary medicines the patient may want to use
- diagnosis and/or triage of symptoms presenting in the pharmacy (is it a new condition, minor ailment or side effect?)
- primary healthcare information such as cardiovascular risk and minor ailments
- preventative care such as wound care, skincare and general health prevention
- tailored therapy options such as dose administration aids, staged supply and opiate replacement therapy
Figure 4.5 Australian PBS safety net entitlement card (left) and concession card (right). Source: Medicare Australia 2014\textsuperscript{11,12}

- health promotion such as weight loss and smoking cessation
- wound care
- ongoing point-of-care monitoring such as blood pressure and blood glucose.

The business difficulty for community pharmacies in Australia is that, historically, these services have been provided at no charge, being cross-subsidised from margins on PBS dispensing and other retail sales. However, as the Community
Pharmacy Agreements have evolved, the Commonwealth Government has been reducing the margin paid to community pharmacies. Other retail pressures have also been reducing margins on non-PBS retail products, so it is becoming more difficult for community pharmacies to provide ‘free’ services. This, in turn, places a burden on community pharmacy proprietors to review their offering and the balance of retail activity, PBS dispensing, ‘free’ clinical services or imposing a charge.

The primary clinical role of a community pharmacist is providing a dispensing service, while the primary clinical focus is medicine safety. The drug being dispensed must be considered in the context of the patient’s other medications (prescription and non-prescription) and conditions. Community pharmacists only have access to a patient’s medication history through their pharmacy, so must develop processes to ask the patient about other medications and background medical conditions. Pharmacists who use dispensary technicians to process prescriptions must also factor this in to their clinical review processes. One method is to have the pharmacist receive all prescriptions from patients and conduct the clinical review, including asking appropriate questions before the prescription is processed.

‘Over-the-counter’ (OTC) medicines in Australia consist of two categories or schedules to the Standard for Uniform Scheduling of Medicines and Poisons: 14

- Schedule 2 or pharmacy-only medicines must be sold by a pharmacist (or assistant under direction of a pharmacist), medical practitioner, dentist, veterinary practitioner or an appropriately licensed person (various conditions). 14
- Schedule 3 or pharmacist-only medicines must be sold by a pharmacist, medical practitioner, dentist or veterinary practitioner. 14 All sales of pharmacist-only medicines must also provide adequate written or verbal instructions at the time of sale, provide a label on the container to identify the source of the product and record the sale if required by state legislation.

Therefore pharmacists in Australia can prescribe and provide these medications without a prescription to treat a range of minor ailments after satisfying themselves of the need for the medicine. This clinical role provides limited diagnosis and prescribing for community pharmacists and can enhance their clinical role.

Community pharmacists are the most accessible healthcare professionals in Australia. Many people consult a community pharmacist for their opinion as their first port of call in the medical system. This provides community pharmacists with a role in triage and other medical issues that may require referral to a medical practitioner, other healthcare providers, a hospital or even to ambulance transport. Pharmacists also provide other services such as wound care, asthma management, diabetes management and health checks (Box 4.4).

Recent changes in healthcare from focusing on illness to focusing on wellness should encourage pharmacists to adopt a more preventative-oriented approach rather than the traditional treatment approach. Community pharmacies can become a destination for preventative healthcare advice and products to enhance wellbeing and preventative monitoring.

MedsCheck is a clinical service introduced and funded under the Fifth Community Pharmacy Agreement negotiated by the PGA for community pharmacies. 15 It is essentially a ‘brown bag’ medication review of the medicines that a patient brings to the pharmacy (Figure 4.6). It includes a written report and discussion of medication-related issues during an allocated and booked time where the pharmacist providing this service is not involved in other pharmacy tasks. MedsCheck is an in-pharmacy
reduced scope version of the previously funded HMR program – see below under Consultant pharmacy.

Community pharmacies provide a range of other clinical services; however, the documentation of these services is sporadic (at best) and sometimes non-existent. Some incentive funding has been provided through various Community Pharmacy Agreements to attempt to improve this situation. However, since Australian community pharmacy systems are geared to dispensing; structural reform would be required to achieve such practice change.

Consultant Pharmacy

Medication reviews were initially funded by the Australian Government for residents of aged care facilities (ACFs) in 1997 following research (later published) by Roberts et al demonstrating the benefits of pharmacist medication reviews in this population. The funded model involves a pharmacist accredited to provide medication reviews, through additional clinical and communication training, comprehensively reviewing the resident’s medications and clinical situation on referral from the patient’s medical practitioner. The accredited pharmacist then provides a written review to the referring medical practitioner and a copy to the ACF with recommendations for the ongoing care of the patient.

This model was extended to similar reviews in the home (HMRs) in 2001. This is a referral service where an accredited pharmacist visits a patient in their home to have access to the patient’s medicines and also provide an insight into the medicines management in the home environment. However, it should be noted that there is no evidence showing that conducting the review in the home provides any better outcomes than a pharmacy/office visit. The review process is a comprehensive specialist clinical pharmacy review of the patient and a written report is provided to the referring medical practitioner.

Pharmacists have two pathways to become accredited – either an Australian program through AACP or undertaking the American Certified Geriatric Pharmacist (CGP) specialty exam through SHPA. Both pathways allow a pharmacist to become accredited to provide medication reviews (Residential Medication Management Review (RMMR) and HMR). Regular reaccreditation assessments are undertaken by both organisations to ensure accredited pharmacists maintain their clinical skills. At the time of writing, there were approximately 2500 accredited pharmacists in Australia.

Both HMR and RMMR can be provided by independent pharmacist practitioners on referral from a GP. These reviews have generated an opportunity for pharmacists to specialise in clinical pharmacy and provide direct clinical services without the need to be tied to a hospital or community pharmacy environment. The focus in both review types is skewed towards chronic conditions and their pharmacotherapy, with the aim of reducing the medication burden on clients by reducing the number of drugs, side effects and/or doses per day. Patients generally appreciate the time spent with them and many accredited pharmacists spend much time reinforcing information about dosing, administration, crushing, etc.

ACF contracts for medication reviews can also bring the opportunity to enhance participation in various activities to improve quality use of medicines (QUM). This can be through educating ACF staff about medication-related issues and becoming a member of the facility’s medicines advisory committee to advise on policy implications of medication usage.

A range of providers have produced computer software to support clinical services both in and
outside community pharmacy. However, a major benefit of the HMR program is there is no strict template for reports, so individual pharmacists can use their flair and judgement to design reports that suit individual GPs. This situation mirrors that of medical specialists and HMR are essentially a specialist service provided for GPs by accredited pharmacists on referral. A major disadvantage of ‘report writing’ software is the inevitable template reports that are produced and the possibility of ‘form fatigue’ among receiving GPs.

Consultant pharmacy also provides some challenges for practitioners as they generally only see a snapshot of the patient’s care rather than a detailed holistic care path. However, this can be ameliorated with regular ongoing reviews, especially in complex patients. Silosim can also be an issue in this process as the accredited pharmacist’s report only goes to the referring medical practitioner and possibly a single community pharmacy. Hopefully this issue will be addressed through the introduction of an electronic health record where all relevant health practitioners will be able to access the relevant information.

From a business perspective, the government fee for HMR and RMMR is fixed. Therefore there appears to be an incentive to select less complex cases to improve productivity and consequently earning capacity. However, since the HMR and RMMR systems are referral-driven, this selectivity is minimised.

Emerging Areas of Pharmacist Practice
Various areas of clinical practice are available to pharmacists in other countries that are not yet available to pharmacists in Australia wishing to broaden their scope of practice and develop their clinical practices. These include:

- pharmacists in general practices
- vaccination
- prescribing rights
- pharmacist practitioner roles
- disease state management.

These developing roles are the subject of research and development in universities and professional organisations. The main obstacles in Australia are developing a business case and payment for services. The majority of the population expects pharmacist services to be free, primarily based on their community pharmacy experiences and the Medicare system for medical consultations. The Australian healthcare system is based on an equity of access model that provides tiered payment structures in the public system to support those with reduced ability to pay.

The other main issue is political – other healthcare professions see pharmacist expansion as a ‘turf war’ and vigorously defend their traditional practice areas. Pharmacists should unite to present a case for broadened clinical services and additional training where necessary. This professional impetus will also drive practice research to demonstrate the benefits of increased pharmacist involvement.

APPLICATION ACTIVITY

Activity 4.1
Discuss the following questions and issues. The activities are best performed by discussing issues in groups of two or three people but may be completed individually.

1. What are the main differences in daily practice between a hospital, community and accredited pharmacist? Consider the nature, intensity and source of their work.

2. Could patient outcomes be improved by better communication between the different pharmacists in Q1? How could this be achieved?
Case Study

A first-year pharmacy student saw the following in a journal and asks you what it all means – especially the underlined parts. Explain any abbreviations used and the role of each organisation or service that is underlined.

‘The PGA and PSA today issued a joint statement supporting the role of the pharmacist in HMR. They said they were proud to be involved in upskilling and accrediting pharmacists to conduct HMR and RMMR. The services provided to consumers were invaluable.

‘The SHPA also supported the statements from the PGA and PSA but added it was also an accrediting body through the CGP pathway. “We represent more than hospital pharmacy”, they added.

‘AACP also noted that accredited pharmacists are instrumental at improving QUM and patient outcomes. “The PBS benefits from the various medication review services our pharmacists provide”.

1. Which of the following is an emerging area of pharmacy practice in Australia?
   a. Liaison pharmacist in the community
   b. Conducting Home Medicine Reviews
   c. Lecturing to pharmacy students at university
   d. Clinical pharmacist review in hospital wards

2. Which organisation represents the interests of community pharmacy proprietors?
   a. AACP
   b. PSA
   c. PGA
   d. SHPA

3. Australian public hospitals receive funding directly from:
   a. The Commonwealth Government
   b. State governments
   c. Local governments
   d. Private health insurers

4. The Pharmaceutical Benefits Scheme funds:
   a. All medicines in public hospitals, some medicines in private hospitals and all medicines in community pharmacy
   b. Some medicines in public hospitals, some medicines in private hospitals and some medicines in community pharmacy
   c. Some medicines in public hospitals, some medicines in private hospitals and Home Medicine Reviews
   d. Some medicines in public hospitals, all medicines in community pharmacy and Home Medicine Reviews

5. The main difference between a hospital pharmacy and a community pharmacy is:
   a. Hospital pharmacists often see a short snapshot of the patient while community pharmacists provide long-term ongoing care
   b. Hospital pharmacists annotate prescriptions and community pharmacists do not because there is not enough room on a prescription compared with a drug chart
   c. Community pharmacists provide long-term care to patients and provide prescription medicines, while hospital pharmacists focus on non-prescription medications
   d. Community pharmacists can provide Home Medicine Reviews, while MedsChecks are only available through hospital pharmacists.

6. Home Medicine Reviews cannot be:
   a. Provided in an aged care facility
   b. Conducted by an accredited pharmacist
   c. Provided on a GP referral
   d. Conducted in a patient’s home

7. One pathway to becoming an accredited pharmacist in Australia is:
   a. Undertake the Certified Geriatric Pharmacist qualification through PSA
   b. Travel to New Zealand to undertake specialist training
   c. Complete a minimum of a master’s degree in clinical pharmacy
   d. Submit case studies, a portfolio and complete multiple choice questions for in-house AACP assessment

8. The HMR and RMMR professional service programs have provided which of the following opportunities for pharmacy practice in Australia?
   a. Enhanced the business viability of community pharmacies by ensuring they conduct all reviews
   b. Provided opportunities for independent consultant practitioners

Answers to end-of-chapter case studies and self-assessment questions can be found at http://evolve.elsevier.com/Kyle/pharmacists/.
c. Expanded hospital pharmacy services
d. Generated additional opportunities for every pharmacist to generate income with no additional training

9. Medication review reports (HMR and RMMR):
   a. Provide a specialist report from a pharmacist to a consumer
   b. Must follow a strict government template
   c. Must be free form with no signs of a template
   d. Provide a specialist report to a GP from a pharmacist

10. Which of the following is not an area of emerging practice for pharmacists in Australia?
   a. Vaccination in a public health clinic
   b. Consulting in a cardiologist practice
   c. Changing prescribed doses while conducting a Home Medicine Review
   d. Reconciling a patient’s medication history during a home visit

References
