Pharmaceutical Society of Australia LTD.
ABN 49 008 532 072


7 October 2014

Ms Hannah Summerhayes
Coroners Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Ms Summerhayes,

Court ref: COR 2007 002556: Investigation into the death of Glen Kingsun

Thank you for your letter on 30 July 2014 and a copy of the findings and recommendations associated with the Investigation into the death of Glen Kingsun, COR 2007 002556.

The Pharmaceutical Society of Australia (Victorian branch) appreciates the opportunity to respond specifically to the following coroner's findings and recommendations:

1. *Finding: "the deceased's medical records also indicate that there was a degree of confusion and uncertainty between the deceased's treating doctors about precisely what type and dose of medication the deceased had been prescribed. In the circumstances, this may have compromised the ability of those doctors to accurately and holistically undertake a risk benefit analysis in relation to any particular prescription and to allocate responsibility for monitoring the safety of the dose."*

This case demonstrates the complexity and challenges faced by health professionals involved in the management of patients with multiple disease states and co-morbidities within our current health system, and the risk of inadequate communication and documentation across the system. The lack of a unified, transparent and consistent one 'source of truth' for a patient's medical history, including their medication history, poses a risk to both the health practitioner and ultimately the patient.

2. *Recommendation: "the Victoria Faculty of the Royal Australian College of General Practitioners, the Australian Medical Association Victoria, The Victorian Branch of the Pharmaceutical Society of Australia and the Victorian Branch of the Pharmacy Guild of Australia meet to discuss the feasibility of collaborating to develop and implement a real-time prescription monitoring system to enhance their Victorian members' ability to provide appropriate care to patients and reduce the harms and deaths associated with poor coordination of care".*

The coroner also referred to the Electronic Recording and Reporting of Controlled Drugs (ERRCD) initiative which has had little progress in Victoria for the last 2 years. Each of the professional organisations listed by the coroner in this recommendation universally support a real-time prescription monitoring (RTPM) system and have worked with the Victorian government to progress this initiative. It is important to note that while this initiative if implemented will provide health professionals an effective tool to monitor the prescribing and supply of a selected group of drugs that are subjected to abuse and misuse, it will only benefit a selected group of medicines and will not cover all general medicines as used in this case reviewed. Additionally, the effectiveness and success of an ERRCD or RTPM system will be to ensure that is has minimal if no additional workload for health professionals to enter and monitor information, and that is seamlessly integrates with existing software programs used.


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For a real time prescription monitoring system to be truly of benefit to cases similar to this of Glen Kingsun, the system must be fully automated and mandatory to all prescription medicines; and all health professionals must have readily access and use the same system and database in their daily routine when managing their patients. This is in fact what the Commonwealth Government's eHealth - Personally Controlled Electronic Health Record (PCEHR) initiative is attempting to achieve over recent years. Such system requires substantial capital investment, regulatory changes and practice support that are coordinated at the national level. This is beyond the capability of the 4 professional bodies identified in the coroner's finding. In addition, the current eHealth patient 'opt-in' approach due to privacy concerns also deems any such system impractical.

In our recent submission to the Victorian Parliamentary Inquiry in Community Pharmacy, the Pharmaceutical Society of Australia (Victorian branch) also commented on deficiencies in communication being the most common contributing factor to the occurrence of medication errors, including shortcomings in communication between GPs and pharmacists. We cited the University of Cincinnati's College of Pharmacy study pairing 1,000 patients who are at high risk for readmission with a community pharmacist. It focuses on patients with complex disease states: heart failure, COPD, pneumonia, MI or diabetes. Based on the pilot, the researchers are estimating a 20% reduction in readmissions if high-risk patients similar to the deceased receive counselling and medication management by a community pharmacist.

In the meantime, the most effective and practical approach to improve the situation and minimise similar cases is for pharmacists, being the expert in medicines and having practical knowledge about brands, dosages interactions etc, to check and provide an updated medicine list every time a medicine is dispensed so that patients can take to prescribers for their information. This service is currently available in the community through the 5th Community Pharmacy Agreement payment system under Medscheck and Home Medicine Reviews. However, the Commonwealth Government has earlier imposed a cap on these paid services, and an alternative funding model is needed so that pharmacists can continue to provide these valuable services to those in need.

In conclusion, a properly implemented real time prescription monitoring system is a useful tool to enhance communication and documentation and prevent medication errors similar to this case. While such system is well beyond the scope and capability of the four professional bodies identified by the coroner's finding, the Pharmaceutical Society of Australia (Victorian branch) is keen and will undertake to meet with the Victorian faculty of the RACGP, the AMA Victoria, and the Victorian branch of the Pharmacy Guild of Australia to explore ways to enhance our members' ability to provide appropriate care to patients and reduce the harms and deaths associated with poor coordination of care.

Yours sincerely,

Michelle Lynch, MPS
Victorian President
Pharmaceutical Society of Australia

Reference:
Delivering better patient care through better utilisation of pharmacists, Inquiry on the role and opportunities for community pharmacy in primary and preventative care in Victoria, Pharmaceutical Society of Australia (Victorian Branch), June 2014