The Prince Charles Hospital

Audit of pharmacist compliance with Queensland's real-time prescription monitoring system in a public hospital

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Background

A real-time prescription monitoring system was implemented as part of the Medicines and Poisons Act in Queensland in September 2021. The updated legislative framework introduced a class of medicines termed 'monitored medicines', which includes all schedule 8 medicines, all benzodiazepines, codeine, gabapentin, pregabalin, quetiapine, tramadol, zolpidem and zopiclone. The Monitored Medicines Department Standard outlines the roles and responsibilities for prescribers and dispensers of monitored medicines. This includes checking a real-time prescription monitoring system, as well as additional documentation requirements where specific high-risk clinical scenarios exist.

Aim

To assess pharmacist compliance with the requirements for real-time prescription monitoring.

Methods

All patients dispensed a monitored medicine between 7th and 13th February 2022 were identified via an iPharmacy stock movement report. Original copies of the discharge prescriptions were reviewed. For patients dispensed a monitored medicine upon discharge, their clinical notes were reviewed and assessed to determine if any high-risk clinical scenarios existed. Where high-risk clinical scenarios existed, two pharmacists reviewed to identify if significant concerns were present. Their medication action plan (MAP) and inpatient monitored medicine prescriptions were also assessed to identify any monitored medicine-related documentation.

Results

64% **Of the time the database was checked by a pharmacist before dispensing**

44% **A high-risk scenario existed**

There were 69 monitored medicines dispensed to 55 individual patients. Pharmacists documented checking of the monitored medicine database on the discharge prescription prior to dispensing 64% (n=44) of the time.

Monitored medicine name	Number of times dispensed	Documentation of database check present
Oxycodone	35	69%
Quetiapine	9	56%
Morphine	8	88%
Oxycodone/naloxone	8	25%
Tapentadol	4	100%
Codeine	1	100%
Temazepam	1	100%
Oxazepam	1	0%
Gabapentin	1	0%
Pregabalin	1	0%

Table 1. Monitored medicines dispensed and documentation compliance

When assessed, there were high-risk scenarios present (as defined by the monitored medicine standard) on 44% (n=30) of occasions. The majority of these scenarios were patients receiving an opioid or benzodiazepine/z-drug for the first time in 90 days; and patients on an opioid and benzodiazepine/z-drug combination.

When independently assessed by two pharmacists, only six cases had medicine-related problems with significant concerns. On two occasions there was documentation regarding identification and resolution of the medicine-related problem.

Case 1:
Patient prescribed new oxycodone/naloxone 10/5mg for discharge. Preadmission codeine ceased and pharmacist documented evidence of advising patient to avoid PRN nitrazepam if experiencing drowsiness from oxycodone/naloxone and amitriptyline.

Case 2:
Patient on Opioid Treatment Program and regular diazepam preadmission, commenced on new oxycodone 5mg PRN. Prescriber documented review of monitored medicines database and discussion with ward pharmacist. Discharge quantity was limited to five tablets, with plans for outpatient follow-up.

14% **Of the time the database was checked by a pharmacist as part of admission history**

Pharmacists documented checking the monitored medicine database as part of their medication history taking process for 14% of patients taking a monitored medicine on admission, and nil pharmacists documented on an active monitored medicine national standard medication chart prescription. It should be noted however that neither of these are legislative requirements.

Conclusion

Checking of the monitored medicine database was performed by pharmacists 64% of the time. This may be an underestimation of compliance as the audit relied upon documentation of the database check on the prescription.

Compliance could be improved by familiarising pharmacists with the required process, development of a standardised template for MAP and clinical note documentation when a high-risk scenario exists and by integrating prescribing and dispensing software with the database.

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