



## Editorial

The global COVID-19 pandemic is still significantly affecting many parts of the world.

In terms of pandemics, although none of us are clairvoyant and could have predicted the impact of the global COVID-19 pandemic caused by the SARS-CoV-2 virus. We should have been prepared for a pandemic/epidemic caused by a potentially unknown pathogen. The World Health Organization (WHO) lists potential pathogens in order of priority based on the perceived risk of public health concern and epidemics.<sup>1</sup> Since 2018, the WHO have listed 'Disease X' among the potential epidemics from potential pathogens. WHO state, 'Disease X' represents the knowledge that a serious international epidemic could be caused by a pathogen currently unknown to cause human disease.<sup>1</sup>

Primary care needs to be prepared for unknown disasters as well as disasters perhaps more well-known or prone to a specific region in which we practice.

### **Covid-19 Testing**

In June 2020, a trial period was conducted on asymptomatic COVID-19 testing in pharmacies in Alberta, Canada. Pharmacies were supplied with testing equipment as part of the government's health service stock and were paid for each test performed. One pharmacist described this as essentially an extension of the everyday service they provide with strep testing.<sup>2</sup>

The trial was found to be effective at increasing the testing capacity, especially given the desire for schools to return to in-person classes for the Fall term 2020.

On September 1<sup>st</sup>, 2020 asymptomatic testing was available for Albertans at participating pharmacies, with Loblaws rolling out testing in all their 264 pharmacies. This increased Alberta's testing capacity by 3,000-4,000 tests per day.<sup>3</sup> This decision was later reversed with the Alberta government removing asymptomatic testing due to the incoming winter and flu season.

While COVID-19 testing being conducted in pharmacies is a great example of collaborative and effective use of available healthcare resources, the steps taken to roll out this service, have left some pharmacists confused and scared. These government level decisions made for a rapidly evolving pandemic situation need to include the frontline healthcare professionals in the decision-making process as they are ultimately providing the services.

*It is imperative that this reliance on and recognition of primary care during COVID-19 does not dissipate post-pandemic but is formally recognised in the health system's planning and preparedness for disasters.*

We need to continue to advocate for the better integration of primary care in disaster management and especially in the planning and preparedness phases of a disaster. Without proper preparedness the response will be

inappropriate. We need to re-enforce the message of the value and essential roles primary care plays in the overall disaster health response.

*Dr Kaitlyn Watson  
Co-chair of the WADDEM Primary Care SIG*

### **References**

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2. Tsuyuki RT, Watson KE. COVID-19 testing by pharmacists. *Can Pharm J (Ott)* 2020;0(0): <https://doi.org/10.1177/1715163520961981>
3. Bourne K. All Loblaw pharmacies, Shoppers locations in Alberta to offer asymptomatic COVID-19 testing. *Global News*; 2020 [cited 2020 Sept 30]; Available from: <https://globalnews.ca/news/7284041/health-officials-to-update-alberta-covid-19-situation-tuesday-afternoon/>

***It is imperative that this reliance on and recognition of primary care during COVID-19 does not dissipate post-pandemic.***



# Australian pharmacist perspectives on COVID-19 vaccination

As COVID-19 vaccines start to be rolled out in several countries, the global focus of COVID-19 management is moving to vaccination. Primary Care plays an essential role in both the detection and prevention of many conditions, and COVID-19 is no exception. In Australia, COVID-19 testing has been primarily undertaken by GPs, nurses, and phlebotomists in a mix of private testing through GP referrals, drive through testing clinics, hospital run respiratory clinics, and GP respiratory clinics. As of the 6th December, Australia has registered more than 10 million COVID tests conducted, however only 0.3% of these have returned a positive result.

As Australia starts planning for COVID-19 vaccination, it is important that who can administer the vaccine and where it can be administered is considered to ensure optimal role out of the vaccination. Optimising pre-existing health system capacity by ensuring the health workforce is utilised to its full potential will assist with vaccination coverage rates.

Between 2014-2016 each State and Territory in Australia passed legislation allowing pharmacists to vaccinate provided they had undergone appropriate training. Pharmacist-led vaccinations have been well received by the public due to convenience and ease of accessibility, providing the opportunity for more people to be vaccinated.<sup>1,2</sup> Additionally, pa-

ndemic modelling has shown that utilising pharmacists as vaccinators allows for target vaccination levels in the community to be reached sooner.<sup>3</sup>

However, there are some challenges around some COVID-19 vaccines being administered by pharmacists in Australia, for example the need for the Pfizer-BioNTech vaccine to be stored at -70°C, and the requirement of two doses of the vaccine.<sup>4</sup> There are also some practice challenges, such as the restriction on pharmacists to only vaccinate in a 'pharmacy', this means that pharmacists in Australia may be unable to provide vaccination services in hospitals, aged care facilities, or mass vaccination clinics which may be established in the future roll out of the vaccine.

In America, pharmacy chains are preparing for mass immunisation by purchasing appropriate freezers, medical supplies, and upskilling staff in COVID-19 vaccination.<sup>5</sup> In the UK, pharmacists will be able to administer vaccines as part of the wider role out of vaccinations, and hospital pharmacists were involved in ordering, receipt, storage, distribution, preparation, and oversight of the COVID 19 vaccination program by the NHS.<sup>6</sup>

Australia plans to include community pharmacists in the later role out of the vaccine administration,<sup>7</sup> however there are no solid plans on utilising them in hospital and aged care. Pharmacists working in

these sectors could provide vital resources in the initial role out of the vaccine to high-risk patients and health care workers. What will be required to optimally utilise pharmacists as vaccinators:

1. Changes to legislation in each state and territory. In Australia each state and territory has different legislation around what vaccines pharmacists can administer. For pharmacists to administer any COVID-19 vaccine, legislation to include the vaccine must be updated.
2. Pharmacists must make their premises align with any new legislative requirements (such as obtaining appropriate freezers to store vaccines in), and ensure staff are up to date with appropriate training in vaccination administration and first aid.
3. Establish a mechanism for recording doses of COVID-19 vaccine and communicating information around immunisation status to other relevant health professionals, such as GPs.

*Dr Elizabeth McCourt  
Secretary, WADEM Primary  
Care SIG*

## References

1. Nissen, L. et al. 2015. Queensland pharmacist immunisation pilot phase 1 pharmacist vaccination - influenza final report. Queensland University of Technology.
2. Hattingh, H et al. 2016. Evaluation of the first pharmacist-administered vaccinations in Western Australia: a mixed-methods study. *BMJ Open*, 6.
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6. Wickware, C. 2020. Pharmacy team first in the UK to prepare vaccination for COVID-19 [internet]. *Pharmaceutical Journal*. [Available here](#)
7. Pharmaceutical Society of Australia. 2020. COVID-19 Vaccine: Utilise pharmacists for large scale rollout. [Available here](#)



# An Australian GP's Perspective on General Practice Respiratory Clinics

The response to the corona pandemic in Australia has included just-in-time adjustments to accommodate issues of patient and healthcare worker (HCW) safety from transmission of SARS CoV2, while maintaining access to healthcare for those with symptoms that could be attributed to SARS CoV2, "suspected COVID," and those without.

In order to do this, cohorting of patients with respiratory symptoms has occurred. As the number of local cases of COVID-19 have waxed and waned during the pandemic, local healthcare systems have had to adjust to accommodate how potentially infected patients are cohorted.

Emergency departments (EDs) in Australia variously segregated their presenting patients into green and red streams, depending on risk of exposure and respiratory symptomatology, but continued to see all presenting patients. Non-urgent surgeries were postponed. Urgent admissions were managed with strict infection protection and control (IPC) practices.

Telehealth was first tracked to allow patients to phone their healthcare provider without risk of exposure for the HCW, or the patient, to any transmission of SARS CoV2. In primary healthcare, a number of general practices and allied health practices closed their doors to face-to-face patient encounters, particularly where there was a shortage of personal protective equipment (PPE), and when the HCW themselves fitted a more vulnerable category. Many general practices managed to separate streams of potentially infectious patients from those without, through creatively reorganising patient flow.

To accommodate a gap in healthcare service created by these changes, with little precedence, GP-led Respiratory Clinics (GPRCs) were rapidly established. The first GPRC opened on 21<sup>st</sup> March 2020 in Sydney. At the peak there were about 149 GPRCs established across urban, rural, and remote Australia funded by the Australian Government.<sup>1</sup>

The role of the GPRCs is to see GP patients with respiratory symptoms to take the load off EDs and to allow general practices to continue to see patients without respiratory systems to maintain ongoing healthcare in the community. The clinics vary, each designed to fit the local community context.

Navigating the early days of the GPRCs was constant work as guidelines were (appropriately) not prescriptive, however this meant there were a lot of decisions and modifications to be made by each clinic based on the local context. The document *Guiding principles for the establishment and ongoing management of GP-led COVID-19 respiratory clinics*<sup>2</sup> was produced by the RACGP with revision from other stakeholders after many of these GPRCs were already established. It was produced partly to ensure documentation of clinic layout and processes to facilitate the establishment of GPRCs in the next pandemic.

I work in a GPRC in the northern part of Sydney, and that region has twice been designated a hotspot (an area with increased transmission).

Challenges I have identified working in a GPRC during this pandemic have included: keeping up with daily changes in the local epidemiological situation and in directions on who fits criteria for testing; large fluctuations in the numbers presenting; breathing 8 hours a day behind a mask and a face shield; trying to communicate with the hard of hearing or those with a strong accent with a mask muffling voices; the requirement to wash hands, change gloves and disinfect between patients; the constant battle and ongoing discussions to ensure the best IPC practices; managing visible fear in some adults and children as they step up to have an oronasopharyngeal swab; and making sure all the members of the clinic team stay safe and feel safe.

However for me, the rewards of working in a GPRC have far outweighed the challenges. The most rewarding element has been the sense of working as a clinic team to deliver essential healthcare for the local community, as well as collaborating with the local ED, the local pharmacies, and the local general practices to ensure that any gap in healthcare is minimalised.

Team work is always important in a primary healthcare team but never more so in a disaster, including a pandemic.

*A/Prof Penny Burns*

*Co-chair of WADEM Primary Care SIG*

## References

1. Wright M, Versteeg R, Hall J. 2020. General practice's early response of the COVID-19 pandemic. *Australian Health Review* 44(5) 733-736. <https://doi.org/10.1071/AH20157>. Available from: <https://www.publish.csiro.au/AH/fulltext/AH20157>
2. Royal Australian College of General Practitioners. 2020. *Guiding principles for the establishment and ongoing management of GP-led COVID-19 respiratory clinics*. East Melbourne: 2020. Available from: <https://www.racgp.org.au/clinical-resources/covid-19-resources/other-health-issues/guiding-principles-for-covid19-respiratory-clinics>



## SIG Updates

### Editorial Committee

#### Co-chairs

A/Prof Penny Burns

Dr Kaitlyn Watson

#### Secretary

Dr Elizabeth McCourt

The Primary Care SIG is gearing up to showcase the amazing work completed by primary healthcare professionals. In order to assist us in this endeavour, please send us a short 30 sec video answering the following questions

- Who are you and where are you in the world?
- How have you helped your community during COVID-19?
- What has been highlighted for your profession during COVID-19?

Please send videos to Dr Kaitlyn Watson – [kewatson@ualberta.ca](mailto:kewatson@ualberta.ca)

***Healthcare is  
the heart of the  
community and  
it needs to be  
prepared to  
keep beating  
during  
emergencies  
and disasters***

## How you can get involved

We have a number of objectives that we wish to achieve in our section and underpin this with an operational plan. We would like to gain your support and input in achievement of these, and furthermore, would like to know how we can assist you in your endeavors.

To express your interest to join the Primary Care SIG, please complete this Google Form

– click [here](#) to access the form

## Feedback

Thank you for your interest in our special interest group if you have any suggestions or questions please contact us as below.

Material is welcome for any of the sections listed in the Newsletter, or under a new category, if that is appropriate. Personal experiences, case and research reports are especially welcome; material is welcome from WADEM members and even non-members internationally.

Email feedback to Dr Libby McCourt – [libby.m.mccourt@gmail.com](mailto:libby.m.mccourt@gmail.com)

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For more information visit the WADEM webpage for the [Primary Healthcare Response Special Interest Group](#)

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