RACGP

RACGP response to Australian Pharmacy Council draft Accreditation Standards for pharmacist prescriber education programs.

Consultation paper two

September 2023

Table of Contents

RACGP response to Australian Pharmacy Council draft Accreditation Standards for Pharmacist Prescriber education programs. Consultation paper two.

Introduction

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide a submission to the Australian Pharmacy Council's (APC) draft Accreditation Standards for Pharmacist Prescriber education programs – consultation paper two which includes the draft Accreditation Standards and draft Performance Outcomes Framework. Additionally, the RACGP thanks the APC for the opportunity for our representatives to attend and contribute to the consultation two's forum.

The RACGP is Australia's largest professional general practice organisation, representing over 46,000 members working in or toward a specialty career in general practice including four out of five general practitioners (GPs) in rural Australia.

The RACGP sets and maintains the standards for high-quality general practice care in Australia and advocates on behalf of the general practice discipline and our patients. As a national peak body, our core commitment is to support GPs and their broader healthcare team to address the primary healthcare needs of the Australian population.

Executive summary

The RACGP provided feedback to the APC in April 2023. This was in response to the first round of consultation for the draft accreditation standards for pharmacist prescriber education programs. As detailed in our previous submission, the RACGP highlighted the need for pharmacists to work as part of a medically supported, integrated multidisciplinary team (such as in hospitals, general practice and Aboriginal and Community Controlled Health Services) if pharmacists are considering expanding their scope of practice to include prescribing. The RACGP is opposed to independent or autonomous prescribing by pharmacists in a retail setting.

A key role of general practice is to guide patients through the complexities of the healthcare system, and prevent unnecessary screening, testing and treatment. Every touch point in general practice provides opportunity to improve on multiple health outcomes. Various health professionals offering the same services, reduces opportunity for coordinated comprehensive care, adds to health system complexity, duplicates, or fragments care, creates patient confusion around role delineation[1] and directs patients away from the essential coordinated medical care provided by their general practice. Fragmenting healthcare has been shown to be less safe and more expensive than models that facilitate continuity of care. Losing this important opportunity for comprehensive and integrated care through task substitution could prove detrimental to patients. Local and international evidence shows that better support for, and use of, general practice is associated with lower emergency department presentations and hospital use[2,3,4,5,6] decreased hospital re-admission rates[7], and significant savings for the healthcare system[8,9,10]. Patient safety is paramount and best protected where multidisciplinary teams are working together to provide coordinated, collaborative and continuous patient care.

The RACGP recognises the important role that pharmacists play in supporting patient healthcare through procuring, advising and dispensing medicines to patients. Like all health professionals, pharmacists should be appropriately supported to undertake their core function within an integrated primary healthcare system.

RACGP position on pharmacist prescribing

- The RACGP does not support independent or autonomous prescribing by pharmacists in a retail setting.
    - RACGP is opposed to pharmacist prescribing in the retail setting because there isn't a clear separation of pecuniary interests and there are perverse risks of financial incentives from prescribing. The unique and siloed retail-health model of community pharmacy incentivises business needs over patient care and is a conflict of interest.
- Retail pharmacy is not an appropriate setting to conduct patient consultations.
- **Pharmacists are not trained in differential diagnosis** and basing any prescribing on an untrained diagnosis is a high risk to patient safety as well as health resource wastage.
- Multiple health professionals offering the same services, reduces opportunity for comprehensive care, adds to health system complexity, duplicates or fragments care, creates patient confusion around role delineation[1] and directs patients away from the essential coordinated medical care provided by their general practice.
- Any expansion of scope of practice must satisfactorily reflect the manifest needs of patients and the primary care system.
- If pharmacists are considering expanding their scope of practice to include prescribing, the RACGP would support pharmacists working as part of a medically supported, integrated multidisciplinary team (such as in hospitals, general practice and Aboriginal and Community Controlled Health Services (ACCHSs).
- **If pharmacists are diagnosing prior to prescribing, then pharmacists should complete the same level of training as a General Practitioner (GP).**
    - GPs complete over a decade of medical training where differential diagnosis is interwoven throughout before prescribing and complete a minimum of 50 hours of continuing professional development per year to maintain expertise and competence.
    - A 2020 Australian study of universities with a pharmacy faculty, identified 26 areas of education that a registered pharmacist would require to provide services within a general practice setting unrelated to prescribing.[1]

Clarification of pharmacist prescribing and scope of practice within the consultation documents

The APC 'Public consultation 1: feedback report' highlighted respondents' confusion over which safe model of prescribing the accreditation standards are relevant to. The feedback report and the released draft accreditation standards and performance outcome measures framework haven't made this any clearer nor have been refined as the consultation progressed. It appears the draft accreditation standards for pharmacist prescriber education programs and performance outcomes framework outline prescribing competency flexibly to encompass all current and future prescribing scope depending on pharmacist prescribing context. From the initial feedback report (post consultation 1), it was documented that feedback found autonomous prescribing inconsistent to the collaborative approach to prescribing, yet now the safe models of non-medical prescribing in the Health Professionals Prescribing Pathway (2013) does not apply to the drafts provided.

In the forum held on 15 September 2023, an RACGP representative was corrected when the term 'autonomous prescribing' was used (even though this term was used regularly during the first round of consultation), and that the terms 'autonomous' and 'independent' are not relevant anymore. As consultation of the accreditation standards continues and content is altered to reflect feedback, there is a risk that organisations and professionals' feedback will not reflect their initial intent and engagement.

The development of the performance outcome framework relies on the NPS Medicinewise Prescribing Competencies Framework as a foundational document. However, with NPS Medicinewise ending operations in December 2022, and the Australian Commission on Safety and Quality in Health Care (ACSQHC) becoming a custodian of its quality use of medicines functions, the RACGP seeks confirmation that this framework remains as a foundational resource. The ACSQHC states having commenced a review of NPS Medicinewise site content.

The RACGP does not support independent or autonomous prescribing that requires a pharmacist to diagnose a new condition and/or requires the pharmacist to recognise, through clinical assessment, the deterioration of a patient or the need to change management for a patient. This requires medical training achieved over a decade of training. The RACGP only supports collaborative prescribing models in team-based settings like hospitals, general practice and

ACCHSs. The RACGP does not support prescribing in retail pharmacy where there is a conflict of pecuniary interest and inability to access comprehensive patient records.

The RACGP continues to be concerned about conflation of diagnosing and prescribing skills and that the role of diagnosis in prescribing is being diminished

Conflation of diagnosing and prescribing skills may present a risk to patient safety. Structured prescribing and protocols that are being used in decision making when supplying medicines for management of symptoms of very minor ailments (where symptoms are likely to resolve themselves over time) presents quite a different level of risk to the use of structured protocols where diagnosis of a medical condition is required. Flowcharts cannot replace a decade of medical training that GPs bring to accurate diagnosis and the continuing professional development of capability and skills in medical diagnosis and management as per the Medical Board of Australia's Registration Standard: Continuing professional development.[11]

Prescribing must be seen within the context of broader clinical care management of the person, where a decision has been made to use a pharmaceutical product, among other management strategies. Prescribing requires in-depth experience and training in diagnosis.

Language that is used in the draft documents instead of 'diagnosis'

The documents provided by APC use language that is representative of the process of diagnosis, to imply diagnostic skills. RACGP asserts again, that pharmacist supply medicines over the counter for symptom management which may or may not resolve on their own, and this not the same as undertaking a diagnostic process. Examples are:

- The NPS MedicineWise Prescribing Competency Framework 2nd Edition has been used by APC to define prescribing:

> *"an iterative process involving the steps of **information gathering**, **clinical decision making**, communication and evaluation which results in the initiation, continuation or cessation of a medicine."*

- Draft performance outcomes framework page 6

> *'Prescribers must clearly document their **clinical reasoning** to facilitate coherent understanding of their decisions…..'*

- Draft performance outcomes: domain 2

> *The pharmacist prescriber uses effective consultation, communication and assessment skills, relevant to their scope of practice, to clearly define the needs of the consumer*

- Draft performance outcomes: domain 2 - 2.1

> *'Apply current knowledge and use appropriate skills to **assess the consumer**.'*
> ***'Establish** or review, and understand, **the diagnosis** according to practice scope.'*

Pharmacists are not trained in differential diagnosis and basing any prescribing on an untrained diagnosis is a high risk to patient safety as well as health resource wastage. If pharmacists are diagnosing prior to prescribing, then pharmacists should complete the same level of training as a General Practitioner. **The RACGP reiterates its concerns about the conflation of diagnosing and prescribing skills and that prescribing is not an individual construct that can be allocated like an administrative task.**

The unique retail-health model of community pharmacy incentivises business needs over patient care, is a conflict of interest and will fragment care.

The RACGP is opposed to pharmacist prescribing in the retail setting because there isn't a clear separation of pecuniary interests and there are perverse risks of financial incentives from prescribing.

- The APC states that they are seeking collaborative practice, however pharmacist prescribing in a retail pharmacy setting will fragment care and duplicate services while directing patients away from the essential coordinated medical care provided by their general practice. Expanding the scope of practice to allow a retail pharmacist to diagnose medical conditions and prescribe medicines decreases patient safety.
- Retail pharmacy is not an appropriate setting to conduct patient consultations.
- Patients often present to a pharmacy with symptoms not yet diagnosed, or health issues that they have self-identified as minor. Pharmacists might provide the patient with pharmacist-only medications to manage the symptoms, however this should not be confused with a medical assessment undertaken by a doctor.
- Patient care becomes fragmented when similar services are offered by multiple health professionals. GPs need a comprehensive patient medical history to ensure that patients are receiving the best treatment for their health issues. Patients' medical records are jeopardised when they receive health services that have no connection to their regular GP practice.

RACGP response to the consultation questions

Draft Accreditation Standards for pharmacist prescriber education programs

Questions for each domain have been grouped and the RACGP's response provided per domain.

Domain 1: Safe and socially accountable practice

Question 1.1.1 In your opinion, do the draft Accreditation Standards adequately describe the expectations of education providers who provide pharmacist prescriber education programs? Please explain your answers.

Question 1.1.2 Do you have any suggestions for additional content that should be added to or amended in the draft Standards? Please explain your answers.

Question 1.1.3 Do you have any suggestions for content you consider should be removed from the draft Standards? Please explain your answers.

Domain 1 – Criterion 1.7

- Further clarification is required on the role of, and relationship between, primary supervisor, supervisor and delegation of supervision to other health professionals; their experience, training, responsibilities and relationships need to be clearly established (Please see response to Question 3).
  - Supervisor must be relevant to the scope of practice of the learner.
  - Suggest that 'supervise' and 'supervision' requires clarification.
- If learners are undertaking work integrated learning (WIL) in their own workplace, conflict of interest between supervisor, learners and learning outcomes of WIL need to be addressed.

Domain 2: Governance and quality

Question 1.2.1 In your opinion, do the draft Accreditation Standards adequately describe the expectations of education providers who provide pharmacist prescriber education programs? Please explain your answers.

Question 1.2.2 Do you have any suggestions for additional content that should be added to or amended in the draft Standards? Please explain your answers.

Question 1.2.3 Do you have any suggestions for content you consider should be removed from the draft Standards? Please explain your answers.

No additional comments.

Domain 3: Program

Question 1.3.1 In your opinion, do the draft Accreditation Standards adequately describe the expectations of education providers who provide pharmacist prescriber education programs? Please explain your answers.

Question 1.3.2 Do you have any suggestions for additional content that should be added to or amended in the draft Standards? Please explain your answers.

Question 1.3.3 Do you have any suggestions for content you consider should be removed from the draft Standards? Please explain your answers.

Domain 3 – Criterion 3.5.

- This criterion would be strengthened through inclusion of the provision of inclusive care and services to diverse and vulnerable groups including those people who identify as LGBTQIA+, people with disabilities, those from culturally and linguistically diverse backgrounds, and with consideration to a person's health literacy. The standards and performance outcomes require further detail to support education providers to develop learning content and assessment that reflect these competencies.
- For consumers to feel safe, pharmacists **must ensure consumer privacy** during initial conversations and then subsequent clinical assessment / consultation / communication / review. Privacy should be clearly stated and expected from the learner in the prescribing process, **not implied**. E.g importance of considering pharmacy modifications such as privacy screens, consultation rooms, secure records, secure messaging.

Domain 4: Learner experience

Question 1.4.1 In your opinion, do the draft Accreditation Standards adequately describe the expectations of education providers who provide pharmacist prescriber education programs? Please explain your answers.

Question 1.4.2 Do you have any suggestions for additional content that should be added to or amended in the draft Standards? Please explain your answers.

Question 1.4.3 Do you have any suggestions for content you consider should be removed from the draft Standards? Please explain your answers.

Domain 4 – Criterion 4.2.

- Recognition of prior learning (RPL) is mentioned in the draft accreditation standards for pharmacist prescriber education programs and Criterion 4.2 states *'A comprehensive description of RPL requirements will be required.*'
    - Further detail is required for RPL criteria and process.
    - For governance, quality and consumer safety, RPL must have clear criteria, consistently applied by education providers, and should be audited.
    - Pharmacist prescriber programs should be classified Level 8 according to the Australian Qualifications Framework (AQF) and as such only limited RPL would be appropriate.

Domain 5: Outcomes and assessment

Question 1.5.1 In your opinion, do the draft Accreditation Standards adequately describe the expectations of education providers who provide pharmacist prescriber education programs? Please explain your answers.

Question 1.5.2 Do you have any suggestions for additional content that should be added to or amended in the draft Standards? Please explain your answers.

Question 1.5.3 Do you have any suggestions for content you consider should be removed from the draft Standards? Please explain your answers.

Domain 5 – Criterion 5.5

- It is not clear whether Criterion 5.5 encompasses primary supervisor and supervisors (e.g., are supervisors health professionals?).
- There must be inclusion of clear governance and training requirements for primary supervisor, supervisor and delegation of supervision.
- Supervisors must be relevant to the scope of practice of the learner.

Program qualification level

Question 2.1 The draft Accreditation Standards state that pharmacist prescriber programs should be classified Level 8 according to the Australian Qualifications Framework (AQF). Does this meet your expectation of the level of learning and qualification type for a pharmacist prescriber education program? Please explain your answer.

Yes, pharmacist prescriber programs should be classified Level 8 according to the AQF and as such only limited RPL would be appropriate.

If pharmacists are prescribing collaboratively within a medically supported multidisciplinary team-based setting, then diagnostic skills are not required as they will have access to medical practitioners for diagnosis. At a minimum, a graduate certificate or graduate diploma level of education should be required for **pharmacist prescribing collaboratively in a team-based setting (e.g. hospital, general practice, Aboriginal Community Controlled Health Service settings).** This should be followed by 6 months practical placement in a general practice or similar for supervised practice.

If the pharmacist is collaboratively prescribing in a team-based setting where medical support is available (e.g. hospital, general practice, ACCHSs) to diagnose and recognise deterioration/need to change management:

- A model similar to NZ would be appropriate.
    - Post graduate certificate, at least 2 years recent and appropriate post-registration experience in patient-facing practice relevant to the area of practice in which they plan to prescribe.
    - Overseas courses vary from around 90hrs – 300 hours of supervised practice (less hours when working in medically supervised settings for limited range of conditions).

If pharmacists are diagnosing prior to prescribing, then pharmacists should complete the same level of training as a GP. Refer RACGP's previous submission.

Work-integrated Learning (WIL)

Question 3.1 Do you believe that it is the role of the education provider to assure the quality of site and learner experience if it is within the **learner's own workplace**?

Yes. There should be standardised minimum requirements established and met for the quality and safety of site(s) and learner experience across all contexts. Education providers must set the expectations and have a means of quality assurance.

Question 3.2 What do you see as the important qualifications and/or skills required of a primary supervisor?

The current draft accreditation standards for pharmacist prescriber education programs state that a primary supervisor is:

'A registered health professional with current prescribing qualifications and experience relevant to the learner's scope of practice who formally agrees to supervise and provide mentorship to a learner.'

However the draft accreditation standards go on to interchangeably use primary supervisor, supervisor or delegation of supervision, mentioning that '…*the role of supervisor will be crucial to successful outcomes*' and '…*clear responsibilities and robust relationships will be required*…' (page 8). Clarification between the roles and their experience and responsibilities needs to be clearly established. Could a primary supervisor be remote from the learner? How do they provide supervision? How many learners can a primary supervisor have at one time? Who is a supervisor? Who is responsible for delegating supervision? It is difficult to provide comment on a role that has not been defined.

For example, the draft accreditation standards for pharmacist prescriber education programs (page 8) states that, *'APC also recognises that, at times,* ***supervision may be delegated to other members of the healthcare team****. As such, the term 'primary supervisor' is used to describe the prescriber responsible for co-ordinating and overseeing learner supervision and the provision of effective mentorship to support their learning, while recognising the valuable contribution of other members of the healthcare team.'*

Are *'other members of the health care team'* supervisors? Are they health professionals? How will delegation of supervision be quality controlled as meeting any established supervisor requirements for the learners learning?

As stated in RACGP's prior submission, a training and assessment program for any supervisors involved will need to be developed alongside the accreditation standards for pharmacist prescriber education programs to provide quality assurance processes for supervisors.

General practice is a very mature industry with a network of general practice supervisors who undertake regular supervisor training with quality assurance monitoring. General practices that supervise registrars must also be accredited practices.

GP feedback is provided during term and end of term on the quality of their training. The APC could consider an Educator assigned to the pharmacist to check learning is progressing appropriately. This would be supplemented by surveys of learner experiences. The pharmacist prescribing training program should also be regularly evaluated.

Assessments

Question 4.1 Do you agree with the inclusion of criterion 5.7 that requires a final summative assessment as evidence that the learner has met the required performance outcomes? Explain your answer.

Yes.

Performance Outcomes Framework

Domain 1 - Professional practice

Question 5.1.1 In your opinion, do the Performance Outcomes adequately reflect the required knowledge, skills and behaviour of a pharmacist prescriber?

'Understanding the consumer and their needs', 'Person-centred shared decision making', and 'Communicate and collaborate', are a large component of three years of GP training and arguably the most complex to teach. A brief education program is unlikely to cover the required knowledge, skills and behaviour to perform those activities effectively and safely.

Similarly, 'Monitor and review' sets standards and outcomes that may be acquired, however pharmacies do not have the software for documenting consultations and making notes about prescribing decisions, nor does the sector have fit-for purpose IT and practice systems for managing consumer recalls.

Question 5.1.2 In your opinion, are the Performance Outcomes observable?

No additional comment.

Question 5.1.3 In your opinion, are the Performance Outcomes measurable?

No additional comment.

Question 5.1.4 Do you have any suggestions for additional content that should be added to or amended in the Performance Outcomes?

Domain 1

- Domain 1 has **accountability** within its general overarching statement; however accountability is not re iterated in any of Domain 1's performance outcomes or expected behaviours. Accountability for consumer assessment and prescribing of medicine cannot be understated.
- The learner must understand their increased responsibilities and scope as a prescriber.

Domain 1 – 1.1
Identify and respond appropriately to actual or potential conflicts of interest that may impact prescribing.

- The RACGP has concerns about pecuniary interests. The unique and siloed retail-health model of community pharmacy incentivises business needs and is a conflict of interest.
- The separation of commercial interests and dispensing roles from prescribing helps safeguard patient safety. Otherwise, there is a risk that prescribing is not evidence-based and can be influenced by financial factors.

Domain 1 – 1.1
Prescribe medicines ethically, with integrity and compliant with applicable professional codes and guidelines

- There is no mention of the responsibility of the pharmacist to ensure consumer privacy during a clinical assessment / consultation / communication / review.
- Privacy should be clearly indicated for the learner in the prescribing process, not implied.
- Suggest that privacy is incorporated as an observable and measurable performance outcome.

Domain 1 – 1.3
Prescribe medicines ethically, with integrity and compliant with applicable professional codes and guidelines.

Suggest re-listing points related to good practice first then follow with lessons learnt from prescribing errors. eg
- Prescribe medicines consistent with applicable regulatory frameworks and organisational requirements for prescribing.
- Prescribe according to the principles of quality use of medicines, including understanding when prescribing a medicine is not in the consumer's best interests.
- Demonstrate an understanding of the common causes of prescribing error and the proactive steps taken to prevent prescribing error.
- Demonstrate a systematic approach to recognising, appropriately managing, recording and reporting errors and/or incidents associated with prescribing and medicines use.

Domain 1 – 1.4
Engage respectfully with consumers and support them to take informed responsibility for their health, including their use of medicines.

- Performance outcome and behaviour must reflect person centered care, that the consumer is central to the health team and collaboration.
- This should be supported by the Australian Charter of Healthcare Rights - open and honest communication, 'I make decisions with my healthcare provider.'

Engage respectfully with other members of the consumer's healthcare team, including informing them of prescribing decisions and outcomes as appropriate.

- Clarification of 'as appropriate' is required for this performance outcome and expected behaviour. Similar to 4.2 if a consumer consents, then prescribing decisions and outcomes must be provided to their healthcare team.
- The lack of clarity of 'as appropriate' in this performance outcome reinforces fragmentation and risk to the consumer.
- Communicating any intervention by the pharmacist to the patient's usual GP is essential to ensure continuity of care and reflects collaborative practice.
- Documentation of prescribing and decision making processes needs to be established and reflect documentation benchmarks set by other health professionals.
- This is where there is benefit to pharmacists working within multi-disciplinary teams (e.g. general practice, ACCHSs, hospitals) where there is access to medical diagnosis, comprehensive patient records and interprofessional support.

Domain 1 – 1.5
Accurately document details of the consultation in the appropriate health record/s according to regulatory, legal and organisational requirements.

- This expected behaviour should reference the consumers (individuals) health record as per 4.2.

Question 5.1.5 Do you have any suggestions for content you consider should be removed from the Performance Outcomes?

No additional comment.

Domain 2: Understand the consumer and their needs

Question 5.2.1 In your opinion, do the Performance Outcomes adequately reflect the expected performance of a pharmacist prescriber?

No additional comment.

Question 5.2.2 In your opinion, are the Performance Outcomes observable?

No additional comment.

Question 5.2.3 In your opinion, are the Performance Outcomes measurable?

No additional comment.

Question 5.2.4 Do you have any suggestions for additional content that should be added to or amended in the Performance Outcomes?

Domain 2

- Privacy is essential to respectfully engage with the consumers regarding sensitive health information.
- There is no mention of ensuring consumer privacy during a clinical assessment / consultation / communication / review.
- As mentioned previously, privacy should be clearly indicated for the learner in the prescribing process, not implied. Privacy should be an observable and measurable performance outcome.

Question 5.2.5 Do you have any suggestions for content you consider should be removed from the Performance Outcomes?

Domain 2 - Understand the consumer and their needs
Establish or review, and understand, the diagnosis according to practice scope.

- Minor symptoms that present could be an indication of deeper health issues particularly for older people living in residential aged care whose health care needs are likely to be complex. Identifying health issues, however minor, requires appropriate medical training spanning triage, diagnosis, and treatment.
- Prescribing must be seen within the context of broader clinical care management of the person, where a decision has been made to use a pharmaceutical product, among other management strategies. Prescribing requires in-depth experience and training in diagnosis.
- **If pharmacists are diagnosing prior to prescribing, then pharmacists should complete the same level of training as a General Practitioner (GP).**

Domain 3: Person-centred shared decision-making

Question 5.3.1 In your opinion, do the Performance Outcomes adequately reflect the expected performance of a pharmacist prescriber?

No additional comment.

Question 5.3.2 In your opinion, are the Performance Outcomes observable?

Domain 3 – 3.2
Recognise and respond accordingly when the needs of the consumer and/or the prescribing decision are outside the prescriber's scope of practice.

- Does the description 'respond accordingly' ensure that optimal care will be provided? A consumer may need support to access health services, and this is an opportunity for the pharmacist to support the consumer and improve health literacy.
- Suggest that further description of 'respond appropriately' is required to ensure consumers safety and reiterate pharmacist accountability.

Question 5.2.3 In your opinion, are the Performance Outcomes measurable?

No additional comment.

Question 5.2.4 Do you have any suggestions for additional content that should be added to or amended in the Performance Outcomes?

No additional comment.

Question 5.2.5 Do you have any suggestions for content you consider should be removed from the Performance Outcomes?

No additional comment.

Domain 4: Communicate and collaborate

Question 5.4.1 In your opinion, do the Performance Outcomes adequately reflect the expected performance of a pharmacist prescriber?

No additional comment.

Question 5.4.2 In your opinion, are the Performance Outcomes observable?

No additional comment.

Question 5.4.3 In your opinion, are the Performance Outcomes measurable?

No additional comment.

Question 5.4.4 Do you have any suggestions for additional content that should be added to or amended in the Performance Outcomes?

Domain 4 – 4.2

Use a structured approach to documenting the prescribing decision and clinical reasoning. Use appropriate systems to document the prescribing decision in consumer records e.g., My Health Record.

- My Health Record currently has no facility for recording notes on prescribing decisions and clinical reasoning.
  - My Health Record will automatically pick up PBS prescribing and Pharmacy dispensing. Pharmacists can upload a medication list that includes non-prescribed medications.
  - There is no scope in event summary or a shared health summary for documenting clinical reasoning leading to a prescription.
  - There's also no scope in My Health Record for management of health problems identified to be managed with non-medical treatments.

Question 5.4.5 Do you have any suggestions for content you consider should be removed from the Performance Outcomes?

No additional comment.

Domain 5: Monitor and review

- Similar to what has been mentioned above, pharmacies will require appropriate software for the documenting of consultations and their clinical reasoning for any actions/decisions made.

Question 5.5.1 In your opinion, do the Performance Outcomes adequately reflect the expected performance of a pharmacist prescriber?

No additional comment.

Question 5.5.2 In your opinion, are the Performance Outcomes observable?

No additional comment.

Question 5.5.3 In your opinion, are the Performance Outcomes measurable?

No additional comment.

Question 5.5.4 Do you have any suggestions for additional content that should be added to or amended in the Performance Outcomes?

No additional comment.

Question 5.5.5 Do you have any suggestions for content you consider should be removed from the Performance Outcomes?

No additional comment.

General Questions

Question 6.1 Is there anything else you think we need to consider when finalising the standards and performance outcomes?

- There is duplication or reiteration of information within the outcomes and behaviours.
- Safety implications of pharmacist prescribing.
  Draft performance outcomes framework: Pharmacist prescriber education programs, page 6.

  Recognising that many consumers will experience multiple morbidities and receive treatment from more than one health professional, the importance of accurate, timely communication is critical to effective collaborative care and optimal health outcomes.

  - This statement is alarming and highlights the patient safety implications of pharmacist prescribing and that the complexity and risks of pharmacist prescribing have not been adequately addressed.

- Impact of pharmacist prescribing on antimicrobial resistance.
  - Antimicrobial resistance is a top global health threat and should be top of mind when developing pharmacist prescriber education program accreditation standards and performance outcomes. There is a body of evidence that shows pharmacists do not have the knowledge and training (even with post-graduate prescribing qualifications) to manage antibiotic prescribing and support appropriate antibiotic stewardship. Contemporary evidence of similar pilots in Australian and overseas demonstrate that pharmacists already over-prescribe antibiotics and other medicines. The Queensland Urinary Tract Infection Pharmacy Pilot (UTIPP-Q), which allowed pharmacists to prescribe antibiotics for uncomplicated UTI in women aged between 18 and 65 years of age, showed evidence that pharmacists did not follow the study protocols and that less than 1% (5) pharmacies provided about 10% of the scripts for antibiotics during the pilot duration to which the report offers little to no explanation.[1][2]

- Clear parameters and accountability around what can be prescribed.
  - Medical practitioners cannot prescribe everything.

- Costs associated with non-medical prescribing.
  - The evidence indicates that more studies are needed to determine cost-effectiveness of non-medical prescribing. An economic evaluation should be considered comparing the pharmacist prescribing model of care to usual care. Internationally and locally, appropriate reimbursement models have been a challenge to the success of pharmacist prescribers. It would be responsible to ensure that this will be the most cost-effective use of limited health resources.

- Ongoing monitoring and review.
  - The Pharmacy Programs Administrator is authorised under its service agreement with the Department of Health to undertake monitoring and compliance in relation to 7CPA programs. The Department of Health and the Professional Services Review agency monitors GP compliance in relation to patterns of service and quality prescribing practices.
  - The APC will need to consider which agency would be responsible for monitoring quality prescribing and patterns of service for pharmacists and ensure pharmacists are audited for compliance.

References

[1] Parker, R., Forrest, L., Desborough, J., McRae, I., Boyland, T. Independent evaluation of the nurse-led ACT Health Walk-in Centre. Canberra: Australian Primary Health Care Research Institute, 2011.
[2] Pereira Gray DJ, Sidaway-Lee K, White E, Thorne A, Evans PH. Continuity of care with doctors – A matter of life and death? A systematic review of continuity of care and mortality. BMJ Open 2018;8(6):e021161-e
[3] Barker I, Steventon A, Deeny SR. Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: Cross sectional study of routinely collected, person level data. BMJ (Clinical Research Ed) 2017;356:j84-j.

[4] Barker I, Steventon A, Deeny SR. Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: Cross sectional study of routinely collected, person level data. BMJ (Clinical Research Ed) 2017;356:j84-j.
[5] Nagree Y, Camarda VJ, Fatovich DM, et al. Quantifying the proportion of general practice and low-acuity patients in the emergency department. Med J Aust 2013;198(11):612–15
[6] Steering Committee for the Review of Government Service Provision. Report on government services. Canberra: Productivity Commission, 2018.
[7] Shen E, Koyama SY, Huynh DN, et al. Association of a dedicated post-hospital discharge follow-up visit and 30- day readmission risk in a Medicare advantage population. JAMA Intern Med 2017;177(1):132–35
[8] Baird B, Reeve H, Ross S, et al. Innovative models of general practice. London: The King's Fund, 2018.
[9] World Health Organization. The world health report 2008: Primary health care now more than ever. Geneva: WHO, 2008
[10] Engstrom S, Foldevi M, Borgquist L. Is general practice effective? A systematic literature review. Scand J Prim Health Care. 2001 Jun;19(2):131-44.
[11] Medical Board of Australia. Registration standard: Continuing professional development. 2023. Australian Health Practitioners Regulation Agency.
[12] Nissen L, Lau E, Spinks J., The management of urinary tract infections by community pharmacists: A state-side trial: Urinary Tract Infection Pharmacy Pilot – Queensland (Outcome Report). Queensland University of Technology. 21 April 2022