australian pharmacy council

Accreditation standards for pharmacist prescriber education programs

Public consultation 1: feedback report

May 2023

ISBN: 978-0-6452524-0-8

[1] Australian Government intellectual property rules

Acknowledgement of Country

We gratefully acknowledge the Ngunnawal people, the traditional owners of the land on which the APC is based. We pay our respects to the Ngunnawal people and recognise their deep connection to this incredible place we now share. We also pay our respects to the resilience, strength, and wisdom of Aboriginal and Torres Strait Islander Elders, past, present, and emerging across the nation.

We recognise First Nations people's vast knowledge in native plants and their uses. Indigenous Australians were our first pharmacists. Country has provided medicines and healing throughout history. We acknowledge this important connection to Country and the impacts colonisation continues to have on this integral practice.

Canberra means meeting place in Ngunnawal, and is a place where people have been meeting, living and learning for thousands of years. We hope to continue this tradition as we work toward our vision of collaborative, committed and safe pharmacy practice.

Australian Pharmacy Council Ltd

(ACN 126629 785)

The Australian Pharmacy Council (APC) is the national accreditation authority for pharmacy education and training. We do this under the National Registration and Accreditation Scheme (NRAS) working with the Pharmacy Board of Australia and Ahpra.

We're an independent, not-for-profit company. Our work protects public health by setting and maintaining high standards of pharmacy education.

We help pharmacists deliver effective health care to meet our community's changing needs. We do this through skills assessments and accreditation of programs and providers.

Table of Contents

Acknowledgement of Country 3

Australian Pharmacy Council Ltd 3

List of Abbreviations 5

Glossary 6

List of Tables 7

List of Figures 7

Background 8

Objective 8

What we need to achieve 8

What we have done so far 9

Timeframe 9

Promotion 9

Consultation documents 10

The feedback process 10

Consultation outcomes 11

- Respondent profiles 11
- Survey respondent profile 12
- Consultation Forum participant profile 12
- Stakeholder interviews 13

Evaluation of responses 13

- General comments 13
- Feedback in response to consultation questions 14

List of Abbreviations

Abbreviation	Meaning
APC	Australian Pharmacy Council
AQF	Australian Qualifications Framework
GP	General Practitioner
HPPP	Health Professionals Prescribing Pathway
IPE	Interprofessional Education
NPS	National Prescribing Service (also referred to as NPS MedicineWise)
NRAS	National Registration and Accreditation Scheme
OHS	Occupational Health and Safety
OSCE	Objective Structured Clinical Examination
PharmBA	Pharmacy Board of Australia
UK	United Kingdom
WHS	Workplace Health and Safety
WIL	Work-integrated Learning

Table 1: List of abbreviations

Glossary

For the purposes of this document, the following definitions apply.

Term	Meaning
Consumer	A person who has used, currently uses, or will use health care services. This includes the person's family and carers.
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.[1, 2]
Prescribing Competencies Framework (The Framework)	A national prescribing competencies framework which describes prescribing expectations for prescribers in Australia, regardless of profession.
Scope of practice	A time sensitive, dynamic aspect of practice which indicates those professional activities that a pharmacist is educated, competent and authorised to perform and for which they are accountable.[3]

Table 2: Glossary

List of Tables

Table 1: List of abbreviations 5
Table 2: Glossary 6
Table 3: Sources of consultation feedback 11

List of Figures

Graph 1: Survey respondents 12
Graph 2: Consultation Forum participants 13

The Australian Pharmacy Council (APC) would like to express our sincere thanks to the individuals, groups and organisations who provided feedback during the recent public consultation. We appreciate and value your input which will contribute to the development of the accreditation standards for pharmacist prescriber education programs.

This report outlines the process that was undertaken for the first round of public consultation and provides a summary of the feedback and comments received from stakeholders. It also outlines the next steps we will take.

Background

The Australian Pharmacy Council Ltd (APC) is the independent accreditation authority for pharmacy education and training programs in Australia. We work as part of the National Registration and Accreditation Scheme (NRAS or National Scheme), which was created in 2010 under the National Law (Health Practitioner Regulation National Law Act (QLD) 2009) 1 and, as such, we work under assignment of the Pharmacy Board of Australia (PharmBA), the National Board responsible for the regulation of the pharmacy profession in Australia.

APC accreditation helps to protect the health and safety of the Australian community by establishing and maintaining high-quality standards for pharmacy education, training and assessment.

The Pharmacy Board of Australia (PharmBA) has engaged us to develop accreditation standards for pharmacist prescriber training programs.

Objective

Our objective is to produce a set of accreditation standards that will:

- ensure graduates are qualified to prescribe medicines according to their scope of practice
- ensure graduates are ethical, safe practitioners for the benefit and well-being of the public we serve
- ensure graduates are flexible, adaptable and responsive to the evolving needs of individuals and communities, and to fully comprehend their role as prescribers within that changing environment.

What we need to achieve

The Pharmacy Board of Australia (PharmBA) has requested APC develop accreditation standards for pharmacist prescriber education programs. The PharmBA has undertaken

extensive work to investigate the capacity for competent and safe prescribing by pharmacists. They issued a statement on this work in 2019. Development of the accreditation standards will be informed by the NPS MedicineWise Prescribing Competencies Framework (2021) which describes the expectations and core competencies for all health professional prescribers

The standards will ensure that pharmacists complete an accredited and approved education program and are competent to prescribe. The PharmBA may use the accreditation standards as part of their submission if they decide to seek Ministerial Council approval of an endorsement for scheduled medicines for pharmacists' registration.

What we have done so far

There are six phases to the development of the standards:

1. Project initiation
2. Preliminary investigations and consultation
3. Publication of findings
4. Public consultation (three rounds)
5. Finalisation
6. Approval

We are currently at phase 4 and have developed this paper as part of the first round of public consultation. During stages two and three we undertook:

- A review of international and national literature of pharmacist prescribing
- An environmental scan of accreditation standards for prescribing training
- Preliminary stakeholder meetings.

Timeframe

Public consultation 1 was from 9th of March 2023 to 14 April 2023.

Promotion

The consultation process and timeframes were promoted via:

- pharmacy media outlets
- social media
- direct e-mails sent to key stakeholders
- APC website

Included in this group were:

- education providers
- pharmacy professional organisations
- consumers and patients
- First Nations people and organisations
- other accreditation councils
- other prescribing professions
- pharmacy students.

Consultation documents

The first part of our consultation process was supported by the following documents:

- Environmental scan and literature review
- Consultation paper 1
- Consultation question survey and template

The feedback process

Stakeholders were invited to submit feedback to the APC nominated areas for consultation via an online survey, written response to targeted consultation questions, a free form written submission or direct conversation with APC.

APC made the following statement on its website during the consultation process and throughout its consultation papers:

> APC will not publish the comments or feedback we receive in full.
>
> In the interest of transparency, we will publish a summary of the major themes derived from the comments and feedback we receive from stakeholders, along with our response to the matters raised from this consultation. Material supplied in confidence, should be clearly marked 'IN CONFIDENCE' and be provided as a separate attachment to any non-confidential material or feedback you give us.
>
> Information we receive that is marked confidential or given in confidence will be treated as such. We will e-mail a link to stakeholders when we publish the summary of the major themes (and our response) on the APC website.

Consultation outcomes

Respondent profiles

We received feedback from 179 stakeholders in response to Consultation Paper 1.

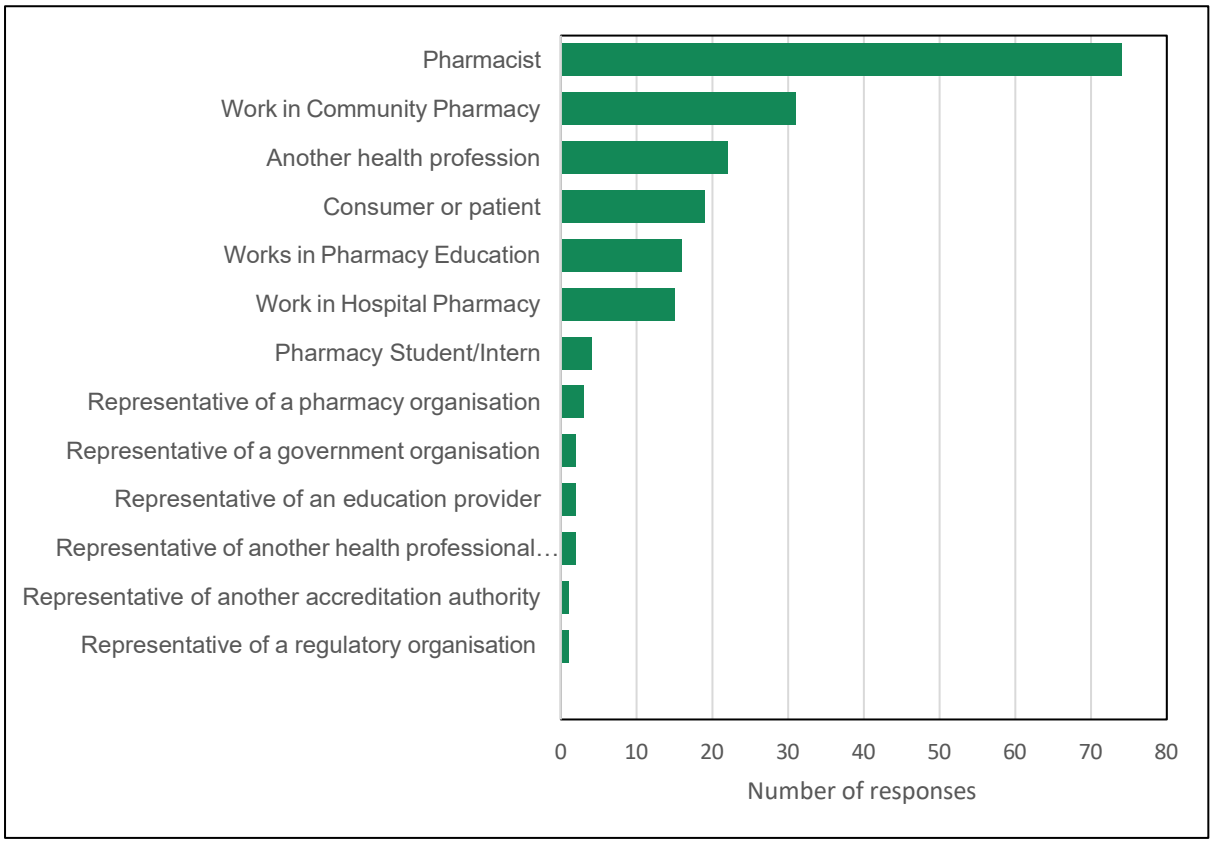
Feedback mechanism	Number of responses
Online survey	183
• Responses that addressed consultation questions	103
Forum participants	53
Written submissions	10
• Submissions that specifically addressed the consultation questions	9
Stakeholder interviews	14

Table 3: Sources of consultation feedback

The following figures provide a breakdown of those who responded, noting that respondents could indicate more than one descriptor in the online survey.

Survey respondent profile

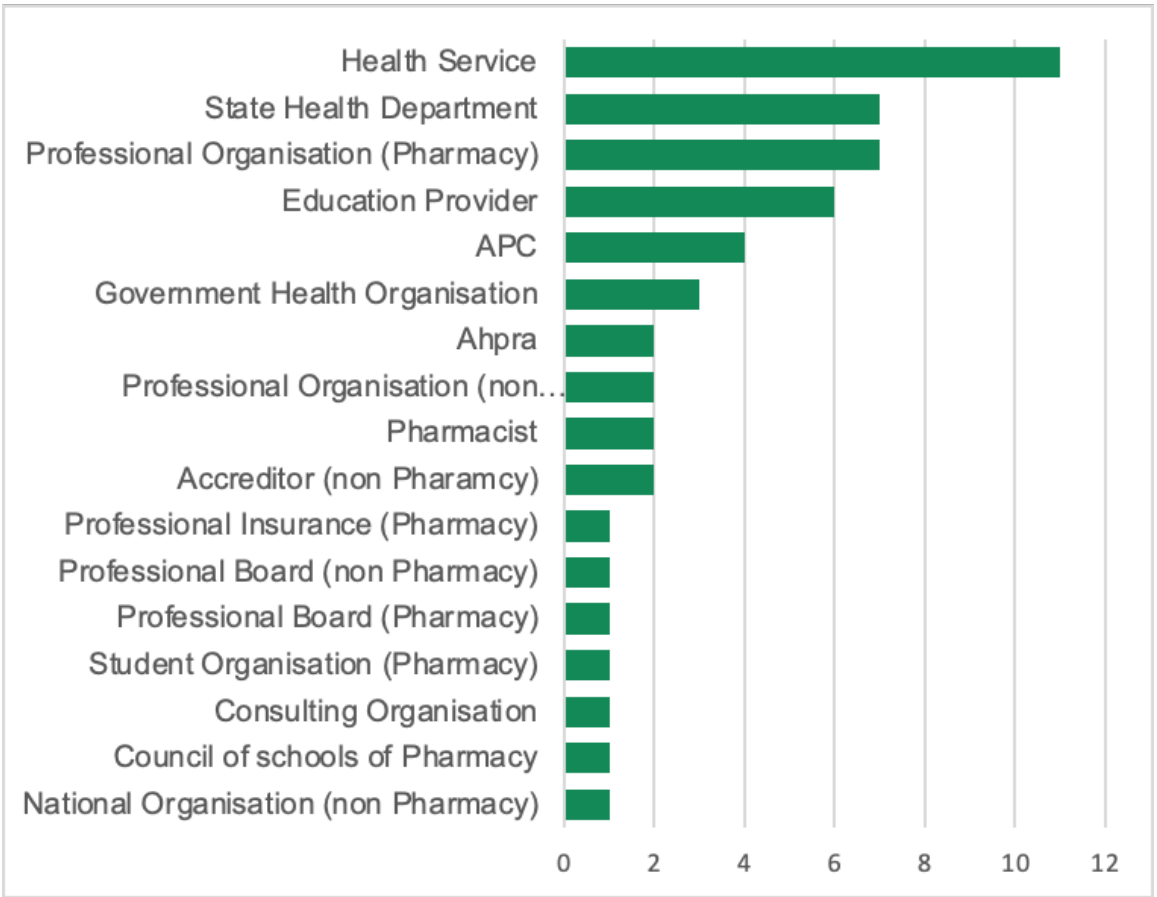
We received 103 complete responses to the online survey. Respondents were grouped according to a number of metrics, as shown in Graph 1.



Graph 1: Survey respondents

Consultation Forum participant profile

A total of 53 attendees participated in the consultation forum, held in Melbourne on 20 March 2023. Of these, 24 attended in person and 29 virtually. Participants were provided an opportunity to contribute their views regarding a range of questions including some of those posed in the online survey. The forum employed a mixture of small group and forum wide conversations. Participants represented a range of professions and organisations. Graph 2 provides a summary of the organisations represented at the forum.



Graph 2: Consultation Forum participants

Stakeholder interviews

APC conducted confidential preliminary consultations with 14 key stakeholders (individuals and organisations) to inform them of our assignment and solicit their perspectives for the project.

Evaluation of responses

General comments

Respondents frequently provided views regarding whether pharmacists should be authorised to prescribe in Australia. Consistent with the advice provided by APC, these comments were deemed outside of scope.

National consistency of prescriber education and training, including programs that provide credentialling for supported prescribing, was viewed as important.

Responses to the consultation questions suggested a level of confusion regarding many aspects of pharmacist prescribing. In particular, the anticipated prescribing context appeared to strongly influence responses, with many respondents focused primarily on prescribing by

community pharmacists without regard for the wider potential for pharmacist prescribing in Australia. In addition, there appeared confusion regarding which model of prescribing the accreditation standards will address. Some respondents described requirements for programs leading to a general qualification for autonomous pharmacist prescribing; however, many addressed their comments specifically to prescribing for defined disease states in the community pharmacy context.

Feedback in response to consultation questions

Question 1: Current terminology to describe pharmacist prescribing across various implementation models is inconsistent and creating confusion. How should this be resolved?

Key Points:

- Terminology associated with prescribing was generally viewed as confusing.
- Numerous comments focused on the implementation of prescribing, including the terminology used to describe *how* pharmacists would prescribe e.g., according to protocol, with/without supervision.
- Differences were identified between legislative definitions of prescribing and the accepted national definition with a suggestion that these should be harmonised.
- Clear definitions and prescribing language were considered important to the establishment of professional responsibility and accountability.
- The terminology proposed by the Health Professionals Prescribing Pathway (HPPP) was considered by most to be appropriate, with the exception of the word 'autonomous' which was viewed as unclear and inconsistent with a collaborative approach to prescribing.
- Respondents commonly called for nationally consistent, simple, clear terminology that aligns with other professions and is readily understood by consumers.
- Existing pharmacist roles in the provision of medicines were viewed as adding complexity to a possible future prescribing role and there was a call for clear definitions to support consumer understanding of these roles including dispensing, supply and prescribing.
- Different views were expressed regarding existing pharmacist roles in the provision of medicines available without a prescription and whether this constitutes prescribing.

Respondents indicated that the terminology relating to pharmacist prescribing lacks clarity and is sometimes misunderstood. Numerous respondents discussed the term prescribing in relation to over-the-counter medicines, with some suggesting this role should not be considered prescribing and calling for a clear delineation between the terminology for pharmacist prescribing and the supply of schedule 2 and 3 medicines. Others felt that providing these medicines requires a similar cognitive process as prescribing for schedule 4 and 8 medicines and should, therefore, be considered prescribing.

General comments relating to terminology highlighted the need for clear, simple, and nationally consistent definitions that can be readily understood by consumers and health professionals alike. Many respondents recommended retaining the terminology used in the HPPP models of prescribing, although commonly rejected the word autonomous, stating it lacked clarity or implied prescribing occurred without collaboration with other health care professionals. Respondents noted that collaboration was essential to prescribing, regardless of context or model. There was a suggestion that it may be simpler to describe prescribing as either supported/supervised/collaborative or independent. This terminology aligns somewhat with colleagues in the UK and New Zealand.

The importance of clarity regarding terminology was noted in the context of professional responsibility and accountability. Medical colleagues argued that diagnosis is a fundamental skill required to prescribe and urged caution with the view that protocol prescribing poses a lower risk to patient safety when compared to an autonomous model.

Other respondents felt that the model under which pharmacists prescribe is irrelevant and that a single title, such as pharmacist prescriber, authorised prescriber or endorsed prescriber should be used to clearly identify pharmacists who are qualified to prescribe.

However, some respondents considered a separate term should be used to distinguish pharmacists qualified to prescribe autonomously. There was a suggestion that alignment with the terminology used by other professions would provide clarity e.g., use of the title pharmacist prescriber for pharmacists authorised to prescribe autonomously. Respondents indicated the importance of clear definitions to support credentialling, legislation, regulation and policy development and to contribute to professional accountability.

Respondents noted a difference between the legislative definition of prescribing (which refers commonly to the generation of a prescription) and the process definition (which describes the steps involved in the prescribing process). Differences between state and territory legislation include variable definitions of pharmacist roles including administer, prescribe, dispense, supply and the associated responsibilities and accountability. Some suggested that this should be addressed at a national level. It was also noted that the current process definition of prescribing does not include adjustment of dose, route, or formulation.

Respondents who identified as medical practitioners tended to recommend titles consistent with prescribing under supervision or by protocol, which may be an indication of their resistance to the autonomous pharmacist prescribing model.

Respondents suggested the accreditation standards should clearly indicate applicability to autonomous prescribing.

Respondents indicated a need for patients to easily recognise who can prescribe medicines and their area of practice.

Question 2: What level of education or training is required to support pharmacist prescribing in Australia?

Key Points:

- Education and training should be consistent with the prescribing model and context.
- Prescribing by protocol or under supervision may require some additional education. Most, but not all, respondents felt this type of prescribing would not require formal postgraduate education.
- Autonomous prescribing would require additional post-graduate education and training.
- Prescriber education programs should be consistent with those offered for other health professions.
- Maintenance of prescribing competence should be addressed.

Numerous respondents indicated that the level of training should be consistent with the model of prescribing and the prescribing context, including the area of practice in which prescribing will occur and associated consumer needs.

Differing opinions were expressed regarding the education level required to support proposed models of prescribing. Consistent with the position of the Pharmacy Board of Australia, the majority of respondents view existing entry-level programs as adequate to prepare pharmacists to prescribe according to protocol, noting that continuing professional development and/or micro-credentialling may be required. While some respondents indicated that existing entry-level programs would also be adequate to prepare pharmacists to adjust prescribed medicines according to patient need, others considered that amendment of a prescription is equivalent to autonomous prescribing, as it is occurring independently and is unlikely to be governed by a defined protocol given the broad range of conditions and medicine that could be eligible. While some viewed existing programs as adequate to prepare pharmacists to prescribe under supervision, others saw a need for postgraduate education and training to undertake this role. A number of respondents suggested a need for national credentialling of programs offered to upskill pharmacists to prescribe according to a structured arrangement or under supervision.

Medical colleagues expressed the view that pharmacists require additional postgraduate education and training that includes a period of experiential learning before gaining authorisation to prescribe according to any model.

Respondents felt that where a diagnosis is required and/or prescribing will be undertaken independently, a formal postgraduate qualification (e.g., graduate certificate or diploma) would be required. Respondents also expressed a view that programs need to cater for current registrants with varying practice experience.

Several medical practitioners indicated that education and training should be equivalent to that undertaken by doctors. This group also viewed pharmacists as lacking the diagnostic skill required to prescribe and suggested for this reason postgraduate education and training would be required to autonomously prescribe.

There was recognition that whilst initially, pharmacist prescribing training may need to occur at a postgraduate level, it would likely be incorporated into entry-level training in the future. Some suggested that initially prescribing programs may be offered in a postgraduate format while simultaneously being incorporated into undergraduate programs as undertaken by other professions in Australia and pharmacists in other countries.

Respondents considered it important to review programs offered to other prescribing professions when designing prescriber education programs.

Although not a focus of the accreditation standards to be drafted as part of this work, the need for ongoing demonstration of prescribing competence was raised as an important consideration.

Question 3.1 What should an education provider consider before applying entry criteria requirements for their programs?

Question 3.2 What entry requirements should be considered and why?

The responses to questions 3.1 and 3.2 were similar and frequently duplicated across both questions. Respondents stated entry criteria should be objective and measurable and aimed at ensuring applicant quality to optimise patient safety.

Key Points:

- Entry criteria for pharmacist prescriber programs was viewed as important by some, but not all, respondents.
- Commonly, post-registration experience (either a required duration or demonstration of competence) was considered an important pre-requisite for pharmacist prescriber education programs.
- A range of additional criteria were proposed.

- Consideration of the entry criteria for similar programs was suggested.

Respondents generally considered that candidate experience should be a consideration, with many stating it should be a pre-entry requirement. Some felt it important to recognise that pharmacist practice currently includes the prescribing schedules 2 and 3 medicines (note also the counter view raised in response to Question 1 above). There were two suggestions relating to how to reflect experience in proposed entry criteria:

(a) Include a required *duration of post-registration experience*. Suggestions ranged from none to 10+ years. Respondents noted that pharmacists use many of the skills required to prescribe and that autonomous prescribing represents an extension of previous experience.

(b) Require candidates to *demonstrate competence* regardless of the duration of experience. Some respondents indicated that experience must be relevant to the area of prescribing, others indicated that relevant experience should be demonstrated rather than simply stated.

Use of the Advanced Practice Framework for pharmacists was suggested as a possible method to demonstrate achievement of relevant experience, knowledge and/or skills.

Other suggestions for consideration or as program entry requisites, included:

- Registration as a pharmacist in Australia, with no history of disciplinary action or conditions to registration
- Recency of practice
- Scope of practice/specialist area
- Prior relevant qualifications
- Candidate competence in a relevant area of practice
- English language competence
- Support of a mentor/supervisor
- Employee references.
- Communicating the motivation to prescribe e.g., by reflective essay or during an interview.

Participants at the consultation forum indicated that pre-entry practice experience should be carefully considered before adopting as an entry criterion noting pros and cons of doing so.

Several GPs felt that there should be a pre-entry examination.

Many considerations fell outside of the scope of education and training program selection. These included patient safety, medicines accessibility, accountability, financial conflict of interest, geographical location (favouring rural and remote practitioners), and pharmacy

consultation facilities.

Question 4.1 How should education providers ensure the principle of interprofessional collaboration is embedded in their training programs?

Key points:

- Respondents indicated a clear recognition of the value of interprofessional collaboration in the context of prescribing practice.
- There was recognition that interprofessional collaborative skill development is a requirement of entry-level programs and an important component of existing pharmacist practice.
- Respondents provided a range of suggestions for the inclusion of interprofessional education in prescriber programs.

Respondents strongly supported the inclusion of interprofessional learning in pharmacist prescriber programs with some suggesting it should be mandatory. Several methods of incorporating interprofessional collaboration into pharmacist prescribing training programs were suggested. Many of the suggestions revolved around work-integrated learning and included workplace-based training activities, experiential placements, observing authorised prescribers, and supervised practice. Additional suggestions included interprofessional case-based learning activities, including other health professionals in the development and delivery of training and the inclusion of specific learning outcomes in the curriculum.

However, several respondents highlighted that access to authorised prescribers for both training and assessment purposes may be difficult given the current levels of resistance towards pharmacist prescribing from medical practitioners.

There was recognition that interprofessional education (IPE) is a current accreditation requirement of entry-level pharmacy programs and a commitment to interprofessional practice is a requisite competency within the National Competency Standards Framework for pharmacists in Australia. As such, pharmacists are already experienced in interprofessional collaboration. It was considered that pharmacist prescriber programs should continue and expand on this philosophy in the context of prescribing.

Participants identified work-integrated-learning (WIL) opportunities as ideal to develop collaborative skills relevant to prescribing, noting that collaborative skills require practical training combined with an understanding of relevant underlying principles. It was noted that although team-based structures exist in some settings e.g., hospital, GP practices, residential aged care facilities, consideration should be given to how IPE is best included for those practising in less structured environments such as community settings.

Inclusion of the multidisciplinary team to contribute to work-based supervision and assessments was proposed as an important contributor to developing collaborative skills. This was highlighted as challenging to some prescribing contexts such as community pharmacy where an innovative approach would be required to facilitate interprofessional input.

Question 4.2 Can you provide examples of interprofessional collaborative learning that have been effective in addressing safe prescribing competency in the context of the multidisciplinary health care team?

Numerous examples of interprofessional learning were provided by respondents; these included:

- Interprofessional student placements
- Interprofessional case-based learning
- Supervised practice
- Development of medication management plans with input from the multidisciplinary team
- Hospital clinical incident review committees
- Multidisciplinary safe prescribing audits
- Partnered Pharmacist Medication Charting
- Medication management reviews
- Development of prescribing policies/guidelines
- Pharmacists teaching in prescribing modules for other professions such as optometry, podiatry, and nursing
- Referral and liaison with other health professionals where prescribing is outside current scope
- Development of communication skills and the skill of including other healthcare team members in your practice
- Developing a mindset that prescribing should not be undertaken in isolation
- Relationship building with other professionals including their input to assessment
- Input of other health professions to curriculum development.

The inclusion of colleagues from other professions in the teaching and assessment of pharmacist prescriber learners was viewed as one way of fostering collaboration in pharmacist prescriber programs

Question 5.1 What factors should an education provider consider when developing an assessment strategy for pharmacist prescriber training programs?

Key points:

- The majority of respondents considered it important for the assessment strategy to focus on the demonstration of prescribing competence while maintaining patient safety.
- A range of assessment methods should be used across the program, including those conducted in the workplace.
- The multidisciplinary team should contribute to the assessment process.
- The availability of adequately trained mentors and assessors is important to support assessments.
- Consideration should be given to the costs associated with developing and undertaking robust assessments undertaken by trained assessors.

Respondents indicated that patient safety should be central to the assessment strategy which should be adequately flexible to cater for a diverse range of practice settings and include a wide range of applicable assessment methods. A longitudinal approach to assessments conducted in multiple settings was considered important. Assessments should focus on both theoretical and practical knowledge and skills relevant to prescribing, with a central goal of ensuring prescribing competence according to standardised, criteria-based assessments. There was a suggestion that all assessments be applied equally to learners and that external validation be applied to ensure validity.

A multidisciplinary approach to assessment, especially in the workplace, was suggested. The possibility that learners continue the program until able to demonstrate competence, as opposed to completion of the program within a set time frame, was proposed. Consistent with the competency based assessment approach, some respondents indicated that assessors should be adequately trained and accredited to undertake assessments.

Respondents identified that developing and implementing a robust assessment strategy inclusive of multiple professions and assessment methods is costly and this needs to be considered in order to ensure sustainability within a program.

Suggestions for assessment methods included: clinical vignettes, development of a portfolio of experiences, case studies, simulated assessments (including role plays, objective structured clinical examinations (OSCEs)), written examinations and oral examinations that allow an opportunity to examine learner logic and assessments that require learners to physically generate a prescription.

There were numerous comments regarding the inclusion of practical or work-based assessment as a component of the assessment strategy. Suggestions included the use of project reports, portfolios, logbooks, workplace visits, entrustable professional activities, and observational assessments.

Several respondents described specific topics that they considered should be assessed. For example, professional values, ethical practice, ethical communication, therapeutic reasoning, prescribing legislation, practice scope, history taking, differential diagnoses, disease state management, therapeutics, interpretation of pathology results, and safe prescribing practices.

Although out of scope for the current work, respondents also indicated that ongoing demonstration of competence is required.

Question 5.2 What factors should an education provider consider to ensure fair, valid, reliable and consistent assessment of learners in the workplace?

Key points:

- The use of a range of assessment methods and assessment opportunities was considered important to demonstrate competence.
- The availability of adequately trained and willing assessors who do not have a vested interest in the outcome of assessment/s was viewed by many as vital to the assessment process.
- Respondents also indicated the importance of ensuring assessments reflect required prescribing competencies, conform to required standards and are undertaken according to clear guidelines and marking criteria.
- Consumer input to the design of assessments was considered important to maintain validity and fairness.

Assessments were considered an important contributor to ensuring program quality and compliance with required standards.

Respondents considered that multiple assessment formats should be used across the training program to provide clear evidence of prescribing competence. The training of assessors was highlighted as an important contributor to robust assessment and the inclusion of consumers in the review of assessments was suggested as important to ensure fair and valid assessments.

It was considered that the assessments should be authentic, mapped to learning outcomes and recognised prescribing competencies and consistent with the Australian Qualifications Framework (AQF) requirements. Other suggestions included the use of clear assessment criteria and marking rubrics as well as local, national, and international benchmarking. Use of the UK Prescribing Safety Assessment as a competency evaluation tool was also suggested.

Some respondents recommended that assessment or feedback from other health professionals should be included, whilst others felt feedback from consumers should also be considered.

Numerous respondents emphasised that workplace assessment should be undertaken by an independent assessor with no conflict of interest. Moderation/marking by multiple assessors was also recommended.

Should assessments be conducted using an electronic format, appropriate IT measures are required to ensure integrity.

A suggestion was made that APC develop a nationally recognised assessment tool to be used by all education providers as part of the assessment program.

Question 6.1 Should there be a similar requirement for Work-integrated Learning (WIL) in pharmacist prescriber training programs in Australia? Please provide rationale for your answer.

Key points:

- Respondents considered supervised practical training essential for the development of prescriber confidence, knowledge and skills.
- WIL should form a core component of the education standards for pharmacist prescriber education programs.
- Respondents indicated that the provision of WIL may be more challenging in some settings than others

The majority of respondents agreed that supervised practical training is an essential component of prescriber education. Many respondents highlighted the importance of mentorship within the experiential component of a program.

It was felt that WIL is essential to the development of prescriber confidence, knowledge and skills, including understanding the patient journey, recognising practice scope and providing context to prescribing. It was also viewed as important to patient safety and collaborative practice and highlighted as potentially relevant to securing professional indemnity.

Respondents indicated the WIL should form a core component of the education standards for pharmacist prescriber education programs.

Importantly, respondents highlighted that certain settings more readily lend themselves to providing adequate WIL experiences due to their structure, access to potential supervisors, and existing training frameworks. These include hospital settings and GP practices.

Question 6.2 What factors might determine how an education provider decides the most appropriate duration of WIL in their program?

Key points:

- WIL was seen as an opportunity to develop and demonstrate competence.
- Demonstration of competence was considered by some respondents to be more important than a specified duration of WIL.
- Factors identified that may impact the provision of WIL included:
    - The availability of appropriately trained supervisors
    - The location of the learner and consequent access to quality WIL experiences and suitable supervisors
    - Cost, including remuneration of supervisors.

Respondents primarily viewed WIL as providing an opportunity to develop and demonstrate required competence. As such, it was considered more important for learners to achieve milestones in competence rather than simply complete a specified duration of supervised practice.

Some respondents suggested that the duration of WIL should be related to the model under which the pharmacist would be authorised to prescribe, whilst others suggested the complexity of the prescribing setting or area of practice should be a consideration.

There was a suggestion that WIL be reviewed regularly to ensure contribution to the development of prescribing competence.

Considerations identified by many respondents included the availability of appropriately trained supervisors and mentors, who initially will likely be sourced from other health professions. The potential challenge of providing WIL in rural and remote geographical locations and other areas where availability of a suitable supervisor and mentor may be

difficult was also discussed. Innovative methods suggested to overcome this included embedding pharmacists in general practice clinics and the use of existing established relationships between community pharmacists and GPs to facilitate supervised practical training.

In order to ensure sustainability within a program, the significant costs associated with designing and providing authentic WIL experiences, including appropriate remuneration of supervisors, was raised as an important consideration.

Question 6.3 What measures should an education provider consider for assurance of the quality of the supervision, the supervised practice site, and the learner experience?

Key points:

- Assurance of the quality of supervision was highlighted as an important issue. This may require supervisors to complete specified qualifications and undertake preparation for the role of supervisor and mentor.
- Respondents suggested that supervisors should be required to demonstrate their commitment to the role.
- Consideration should be given to which professionals can supervise pharmacist learners, noting that initially there will be few pharmacists qualified to undertake this role.
- A range of quality assurance initiatives were suggested to ensure the quality of the WIL experience. These included: accreditation of sites providing WIL, learner-to-mentor ratios, attention to Occupational Health and Safety (OHS) and Workplace Health and Safety (WHS) matters, collection of feedback from a range of sources, communication between education providers and WIL sites.

Considerations raised by respondents focused on the quality of supervision including the required training, and possible credentialling, to undertake the role and their commitment to the task. Respondents suggested there should be standards for supervision, and supervisor training should be adequate to prepare them for the role. Some respondents highlighted that supervisor competence should include both teaching and mentoring ability.

Practical considerations raised included the role of the education provider in ensuring appropriate supervision and whether supervision must be undertaken by a pharmacist. The stipulation that a range of health professions contribute to work-based training was raised; however, the possibility that this might exclude some pharmacists from undertaking training in settings where this is not possible was a counterargument to this proposal.

Other considerations include the appropriateness of the site, with many respondents suggesting sites should be accredited to ensure the quality of experiential learning consistent with anticipated prescribing scope. The possibility of learner-to-mentor ratios was raised as an important possible quality indicator as were adequately addressing OHS and WHS matters and learner support. A range of quality assurance initiatives were suggested by respondents, including learner reflections and feedback, informal and formal feedback, program completion rates, employment outcomes and learner grades.

Regular site visits and site audits were also recommended, and respondents indicated that clear communication between education providers and WIL sites was essential.

Question 7.1 Is there anything else you think we need to consider when developing the standards?

A range of issues were raised for further consideration:

- Accreditation standards should be acknowledged as national.
- Attention to the appropriate management of the role of community pharmacists and the possible conflicts of interest relating to prescribing safety (the conduct of the 'second check' and how this works operationally where a community pharmacist prescribes medicines) and pecuniary interest. There was frequent commentary regarding the need to separate pharmacist prescribing from dispensing.
- Accreditation standards should address the need for recording of prescribing, including in electronic records.
- Concern regarding the potential cost of training should be addressed.
- Standards should ensure prescribers are safe, efficacious and judicious in their prescribing.
- The importance of developing standards that ensure quality and competence and the credibility of pharmacist prescribing should be paramount.