APC Review of Accreditation Standards for Pharmacy Programs

australian pharmacy council

Consultation Two Summary Report

The Australian Pharmacy Council (APC) would like to thank the individuals, groups and organisations who provided valuable feedback during consultation phase 2 on the draft Accreditation Standards. The feedback has been evaluated and changes have been made to the Standards as a consequence.

This report outlines the process that was undertaken for the second phase of consultation on the 2019 review of Accreditation Standards for pharmacy programs, and provides a summary of the feedback and comments received from stakeholders. It also outlines the changes which were made to the draft Accreditation Standards, and the next steps to be taken.

Background

The Australian Pharmacy Council (APC) is appointed by the Pharmacy Board of Australia (PharmBA) under the National Registration and Accreditation Scheme (NRAS or National Scheme) as the independent accreditation authority for pharmacy education and training programs in Australia, and also provides accreditation recommendations to the Pharmacy Council of New Zealand (PCNZ). One of the responsibilities of accreditation authorities is the regular review of Accreditation Standards, and in 2019, APC is reviewing the

- Accreditation Standards for Pharmacy Degree Programs in Australia and New Zealand (2014)
- Accreditation Standards for Australian Pharmacy Intern Training Programs (2010)

The PharmBA has sponsored and funded this review.

Objective

The objective of this review is to produce a set of accreditation standards that will ensure that graduates are:

competent and qualified to practise as pharmacists

- socially accountable, ethical and safe practitioners for the benefit and well-being of the public
- flexible, adaptable and responsive to the evolving needs of individuals and communities
- equipped with the skills which will allow them to adopt as-yet-unknown scopes of practice which will emerge during their careers, through a commitment to lifelong learning

Process to date

The APC is required under the National Scheme to consult widely with stakeholders in the development of revised Accreditation Standards. This consultation has been undertaken in two phases.

Consultation phase 1

In October 2018, APC published an initial consultation paper and sought written feedback from stakeholders and other interested persons between October and November 2018. The summary report from consultation phase 1 is available on the APC website.

Draft Accreditation Standards

The first draft of the Accreditation Standards were developed using a range of sources, including

- an external review of the current national and international literature
- feedback from consultation 1
- review of new and draft pharmacy Accreditation Standards from relevant jurisdictions
- review of new and draft Accreditation Standards from related health professions
- the input of the members of the project Governance Committee and Reference Group

Consultation phase 2

The draft Accreditation Standards were released in March 2019, and feedback was sought during March and April. Face-to-face consultations were held in Canberra and Brisbane, and written feedback was also received. The consultation paper also foreshadowed the development of Performance Outcomes to support the revised Accreditation Standards.

Consultation phase 2 outcomes

A total of 24 individuals attended the face-to-face consultations, and 15 written responses were received from individuals and organisations representing both the professional and educational sectors of pharmacy. This paper summarises the key themes which emerged from the consultations and feedback, and describes the responses made to the issues identified.

Introduction

A summary of the major issues identified by respondents and the response to these issues is provided in a series of tables. A number of respondents included considered and helpful comments on matters which are outside the scope of the Accreditation Standards and/or the responsibility of other organisations such as the Pharmacy Board of Australia. In addition, a number of comments and suggestions are applicable to the Evidence Guide and/or Performance Outcomes rather than to the Accreditation Standards themselves.

How well do the Accreditation Standards address their objective?

There was general agreement that the Standards address the objective, however this was accompanied by a clearly expressed desire to see the Evidence Guide and Performance Outcomes before making a final judgement. The focus on social accountability, and safe and accountable practice was commended and considered to be very appropriate. There was agreement that the Standards are future-focused and able to be adapted through changes to the Performance Outcomes as the profession evolves.

Glossary/terminology

Respondents indicated that additional clarity around a number of terms would be helpful. The table below summarises key suggestions and how they have been addressed.

Term to be clarified	Response
Responsiveness (particularly the time frame which was appropriate)	This was interpreted as responsiveness to change, and means that change should occur within a reasonable time frame taking into account factors which facilitate and constrain the processes required. It is not possible to define a time frame for every circumstance; therefore this has not been incorporated into the Glossary. Incorporation into the Evidence Guide is suggested.
Safety/safe	It is suggested that this be framed around WHS guidelines, but it is difficult to be precise and comprehensive. Incorporation into the Evidence Guide is suggested.
Diversity and how it is evaluated	This is interpreted as relating to diversity in placements since cultural diversity is defined in the Glossary. Incorporation into the Evidence Guide is suggested.
High standards	This has been changed to “endorsed standards” in criterion 1.4.
Fitness-to-practise (particularly increasing the focus on health and wellbeing of students and interns)	Changes have been made to the definition in the Glossary. It has also been strengthened in the Performance Outcomes. (For additional comments, please see following tables.)
Quality	The feedback was not clear about the context for increased clarity on this term. It could refer to the quality of WIL so this aspect could be included in the Evidence Guide.

Identified limitations of the Accreditation Standards

Respondents identified a number of perceived limitations within the draft Accreditation Standards. The table below summarises key suggestions and how they have been addressed.

Perceived limitation	Response
Too many companion documents, could be integrated into one document	No changes have been made; all documents are considered to be appropriate and necessary.

The definition of 'fitness-to-practise' is too limited and needs to include positive elements such as resilience, mental health and physical wellbeing. The Standards need more focus on preparing the student or intern for dealing with the challenging and complex situations faced by pharmacists today and into the future.	These are clearly important, but it is difficult to hold education providers to the responsibility of ensuring these elements. Modifications have been made to the definition to include the concepts of conduct, performance and health as outlined in the National Law, and the Performance Outcomes have been strengthened.
It is unclear if the extent of duplication between the reporting requirements for TEQSA and APC has been fully minimised.	No changes made.
The balance between key inputs and outcomes within the draft Standards is still weighted towards describing processes.	No changes made.
There is limited formal reference to safe and effective work integrated learning for interns.	It is suggested that this be framed around WHS guidelines, but it is difficult to be precise and comprehensive. Incorporation into the Evidence Guide is suggested.

Suggestions for improvement

While many of these comments were made under the "Limitations" question, they appear to be suggestions for improvement rather than simply pointing out perceived deficiencies. The table below summarises key suggestions and how they have been addressed.

Suggested improvement	Response
There should be further opportunities to reduce duplication and improve streamlining between TEQSA and other health program accreditation requirements.	This will probably only become apparent with use of the Standards.
Clear guidance is needed on the level and type of evidence required to meet the Standards.	This is the purpose of the Evidence Guide and will be addressed in that document.
Clearer distinction is needed between what is expected of the HE organisation and staff, ITP organisations and staff, students, interns, and preceptors given their significant differences in responsibility.	It is not clear what is meant. No changes made.
Some programs may need significant support in implementing criteria 3.3, 3.4 and 3.5 to ensure that there is meaningful and appropriate engagement with Aboriginal people and communities to recognise the diversity and reduce the risk of a 'tick box' mentality and/or an homogenised approach.	It is not clear how such support would be provided or by whom. Some material may be included in the Evidence Guide.

A greater focus on developing resilience, professional self-regard and skills to deal with challenging situations would be valuable for students and interns.	See comments in previous tables regarding fitness-to-practise.
A diagram depicting the association between Competency Standards, Performance Outcomes, and Accreditation Standards may be helpful for readers who are unfamiliar with some of the terminology.	Relevant mapping will be undertaken, and additional suggestions can be made for resources which providers may find useful.
Care needs to be given to specifying some inputs e.g. face-to-face hours for undergraduate and ITPs. These programs are just as much about relationships and communication as a healthcare professional as well as learning the necessary content.	The feedback regarding this issue was not conclusive in relation to specifying the number of hours of face-to-face engagement. Some modifications have been made to the Notes for Criterion 3.1 and will be further addressed in the Evidence Guide.
The concept of innovative and flexible programs is welcomed. However, evidence to support innovation should be underpinned by rigorous evaluation.	This is not within the scope of Accreditation Standards.
Some clarity may be helpful in delineating the responsibilities of the DPs and ITPs for delivering content such as cultural safety training. It was suggested that localised cultural training and experiences for students and interns relevant to their place of study, WIL, or supervised practice sites would be preferred. This would allow genuine engagement and connection with the history of the area and traditional custodians, and the local drivers of health.	This is a helpful suggestion but difficult to include in Accreditation Standards without creating difficulties for providers. It may be appropriate to include in the Evidence Guide.
It is an expectation that WIL sites meet a certain standard, which is not defined. The Standard also refers to monitoring of such sites but does not discuss actions that might be taken if the site is consistently performing below expectations. To aid the development of professional practitioners, unsuitable sites should be prevented from accepting students or interns until the minimum standards can be achieved.	The Accreditation Standards create flexibility for providers to set their own standards and to determine how and when to select or reject particular sites.
A clear statement of intent for each Domain and/or Standard would be helpful to ensure understanding of the purpose of each criterion. There is an inconsistent approach to how these are stated or included throughout the draft Standards.	It is not clear what is wanted here. The format used is consistent with other professions' Standards and no other feedback suggested changes to this wording. No changes made.

Differential requirements for degree programs and intern training programs

A number of issues were identified where additional clarity would be helpful regarding the obligations of Intern Training Program Providers (ITPPs) in comparison to Degree Program Providers (DPPs). The table below summarises key issues and how they have been addressed.

Issue	Response
Some concern was expressed about inherent requirements for 'fitness-to-practise' and how these would be determined, assessed and monitored, especially in the context of ITPs who may not have the same support as universities to manage student disabilities or special needs.	A note has been added to Criterion 1.3 to indicate this does not apply to ITP providers. Other changes have been made are outlined in previous tables.
There will need to be clear articulation of difference in requirements for staff, student vs intern preceptor skills and responsibilities and placement site requirements if combined standards are to proceed.	This should be addressed in the Evidence Guide.
Criterion 1.7 supports the quality and safety of WIL sites by requiring providers and sites to have, meet and monitor against 'documented standards'. There are concerns that this will potentially create a massive burden on providers as well as WIL sites depending on how it is handled. Where WIL sites may have students from multiple providers, there may be different or conflicting expectations for sites and preceptors which could create confusion.	Criterion 1.7 has been split into 1.7a and 1.7b and significant changes made. The responsibilities for providers who allocate sites are higher than those providers (eg ITPPs) who are not involved in the selection of sites.
Any quality assurance mechanism must consider resource implications including time and cost for preceptors and placement sites, and consider existing quality assurance systems already in place such as QCPP as a potential quality indicator. The costs associated with development of resources such as training, and the monitoring of sites, needs to sit with the provider and not impose additional cost to the pharmacies who supervise students/ interns.	Changes have been made to clarify responsibilities and included in Criterion 1.7b.

It was suggested that a step towards quality assurance of sites and preceptors could be a clear and defined Pharmacy Board standard in relation to 'supervising practice' - which would apply to overseeing student placements and supervising interns - encompassing wording that describes the requirements of an approved preceptor versus a supervising pharmacist, and potentially some defined wording in a Board standard to clearly outline the requirements for individual preceptors. The 'monitoring' by providers similarly would be more consistent and streamlined if there was a Board standard to monitor against, rather than multiple standards from multiple providers.	This is desirable but is outside the scope of the Accreditation Standards.
A strong belief was expressed that sufficient face-to-face interactions between interns within intern training programs are critical for professionalisation of interns, opportunities to debrief and reset; it was further suggested that physical interaction is important and cannot be substituted by video links.	As noted previously, some modifications have been made to the notes for Criterion 3.1.
A strong belief was expressed that there is a need for a minimum duration of an ITP; in the previous Standards this was defined as 6-9 months.	Additional wording has been included in the notes to Criterion 3.2, but a mandatory duration has not been specified since this would contrast with the general tenor of the Standards.

Other issues

A number of other issues were raised, and the table below summarises them and how they have been addressed.

Concern	Response
Criterion 1.6 only mentions community and hospital settings as expected WIL sites. Support was expressed for inclusion of 'areas of workforce need' as an expected WIL opportunity. Rural and remote pharmacies are finding it increasingly difficult to recruit and retain pharmacists and therefore provide appropriate access to health services. An experience in rural or remote Australia as a student would increase the likelihood of students returning as interns or pharmacists in the future. Stating the minimum input as 'areas of workforce need' allows for responsiveness to other national health priority areas.	Modifications have been made to the wording to reflect this concern.

Concerns were raised regarding the need for a mandatory minimum duration of WIL for hospital and community practice to be included in the Standards; one option suggested that this minimum be preferably at least 3 weeks of each, which may be enhanced by, but not replaced with, simulation.	Feedback from consultation 2 was mixed regarding the requirements for WIL. While some respondents strongly supported the inclusion of hospital pharmacy WIL as mandatory, others supported a more nuanced approach where quality and diversity were foregrounded. The research strongly supports the conclusion that the nature and quality of WIL are critical and thus the approach has been taken that while hospital WIL experience is highly desirable, providers should be encouraged to seek a wider and more diverse range of WIL settings.
It was suggested that the notes accompanying Criterion 1.7 add another layer of administration for universities and a possible burden particularly on community pharmacies or those operating privately outside of government organisations, given that there are currently other processes and legislative requirements in operation.	Significant changes have been made to Criterion 1.7 as outlined previously.
Providers may need to develop fitness-to-practise policies and procedures.	This is an expectation under the principle of the social accountability of providers.
The issue was raised regarding facilitation of the transition between degree program and intern year, particularly where the DP may have outcomes which are at an advanced stage on the performance outcomes continuum.	The intent of the current changes is to enhance this transition and provide clarity for providers by articulating the expected Performance Outcomes at the end of a degree program. It is acknowledged that DPs may produce graduates who have exceeded the minimum performance level on one or more Performance Outcomes, but the intent is to provide ITPPs with some degree of clarity on the minimum performance levels expected of commencing interns.
The need to socialise terms such as 'social accountability' (and others in the glossary) to the wider profession was raised.	This is a critical point and should be considered as a key element of a communications strategy.
The need to adequately prepare preceptors was raised.	This is critical but out of the scope of Accreditation Standards for degree and intern training programs.
It was suggested that regular reporting and CQI processes could usefully complement the processes associated with reaccreditation cycles.	There is strong justification for increasing the information required as part of annual reporting, and this is expected to reduce the burden associated with re-accreditation applications.

The ability for larger programs to offer a 4+1 program (degree plus intern year) as an integrated qualification may have the potential to create a marketable point of difference and/or undermine the credibility of programs who are only able to deliver the degree program. Some thought needs to be given to how best to continue the separation of the degree and the intern program if a single accreditation model is to proceed.	It is not expected that many degree program providers will seek to implement an integrated program therefore the status quo is likely to be the norm for the foreseeable future. Significant changes to the Registration Standard would be required, and other barriers would also need to be addressed by providers before an integrated program would be possible.
The balance between key inputs and outcomes within the draft Standards is still weighted towards describing processes. For example criterion 2.1 requires a clear operational unit (School of Pharmacy) with autonomy, however, a team may be able to achieve authority and responsibility for designing, implementing, evaluating and resourcing a program without the need for a separate autonomous unit.	No changes made.
A single set of standards for programs of study (degree) and intern training standards was not supported by the feedback from consultation 1.	The support was considered to be strong over all of the feedback opportunities available.
The draft Standards are essentially silent on any specific requirements which may constrain innovation, with the exception of the use of simulation as a way to prepare students for WIL. If innovative programs and approaches is a key objective of the draft Standards, then these should be articulated in a criterion in Domain 3.	The highlighted text is not a key objective, as it is neither possible nor desirable to mandate innovation. The Standards have been developed in such as manner as not to constrain innovation that is promoted by an education provider.
Performance Outcomes based on the Australian Competency Standards Framework may not be relevant to New Zealand providers and considerable expense would be incurred in attempting to align closely.	The wording has been modified to reflect the New Zealand Competence Standards as the equivalent to the Australian Performance Outcomes.
Although research is a competency standard it is not included in Performance Outcomes or the Accreditation Standards Framework.	It is included in Criterion 3.9 and the Performance Outcomes.

Criterion-by criterion suggestions for change

No.	Suggestion	Response
1.1	Suggest splitting into two parts, focusing on cultural safety in its own right.	Not supported, no change made.
1.1, 3.1	There may be a fair degree of overlap between criterion 1.1 and 3.1 which could possibly be avoided to streamline the documentation process.	Not supported, no change made.
1.3	The competency aspect is intended to ensure that students/interns have demonstrated appropriate levels of knowledge, skills, behaviours and attitudes prior to interacting with patients and the public. This may take the form of achieving the appropriate level in Entrustable Professional Activities or other types of assessment. This may be challenging to achieve and not entirely necessary depending on the type of interaction with the public that is planned. For example, students in their first semester of a specific program have a discussion with an independently living older person to practise the communication skills they have been learning. They have not been assessed on these skills, however the activity and reflective task they are required to complete indicate it to be an extremely valuable experience.	This is a good point, and has been addressed in the Notes.
1.3, 1.6	Suggest that the notes specify that assessment of students'/interns' achievements be done with reference to WIL and that WIL be assessed robustly and summatively as a measure of students'/interns' achievements.	Not supported, no change made as considered overly prescriptive.
1.4	Who decides the standards and what happens if an intern or staff member breaches them?	This has been clarified by referring to profession-endorsed standards of practice and conduct.
1.5	Suggest adding the words 'Prior to graduation' at the beginning. The wording appears to require assessment of graduates after they complete the program.	The criterion has been modified to reflect the comment, although with different wording.

1.2-1.7	The notes under criterion 1.5 state that 'it is likely that degree programs will assess students at different levels of depth and breadth compared to ITP providers, commensurate with the potential risk to the public'. This difference is relevant in a range of criteria for example, 1.2 - there is a clear difference between concepts like 'effective fitness-to-practise monitoring' between students and interns in actual practice settings and clarity on how roles are delegated chronologically during their progress would be helpful.	This is covered more in the Performance Outcomes, but some modifications have been made for clarity in the Standards.
1.6	Include 'areas of workforce need' as expected WIL sites.	Wording added.
1.6	Require compulsory placement in hospital and community settings.	Wording changes have been made but have not mandated hospital placements[1].
1.6, 1.7	This domain could benefit from also taking into account more clearly the role of the student and preceptor to ensure the safety of people in non-traditional settings and emerging services (eg nursing homes, Aboriginal Medical Services, General Practice, delivery of vaccinations etc).	These points are covered under Criteria 1.1, 3.4 and 3.5.
1.7	Split into 2 to account for differences between DPs and ITPs.	Criterion 1.7 has been split and significant changes made in response to feedback.
1.8	Suggest that other relevant legislation and Guidelines be stated explicitly.	No changes made as it is considered impossible to be comprehensive and responsive to all changes as they occur. Guidance may be included in the Evidence Guide.
2.2, 3.3	These criteria are not achievable for accredited programs which are offered offshore (ie in neither Australia nor New Zealand).	Noted, but this will result in a similar situation to the current Accreditation Standards.
2.5	The head of school should not have to be restricted to a pharmacy professional however the lead of the program should be a registered pharmacist, as registered pharmacists have the experience and context to appropriately guide the development and maintenance of the program and allocation of resources to achieve the program outcomes.	This is considered too restrictive in that the most appropriate lead may have overseas qualifications but not be registered in Australia/NZ; the onus remains with the provider to outline the way pharmacy leadership is provided.

1 Feedback from the Reference Group and Governance Committee following the close of the consultation period indicated that hospital placement should be mandatory; this was subsequently incorporated into the Accreditation Standards

2.5	Concern was expressed about the ability of the leader of a unit to provide effective leadership and advocacy of the pharmacy program if they do not have intimate knowledge of the profession. The risk of the pharmacy program's status and resourcing within the university could be reduced and have an impact on the ability of the program to attract and graduate students.	This is a good point, but it is not possible for APC to mandate the structure of universities; many Schools are located in larger administrative units which are led by non-pharmacists, and as above the onus remains with the provider to outline the way pharmacy leadership is provided.
2.5	Professional and academic leadership, engagement and advocacy for the profession within and beyond the provider organisation may not be the remit of the designated leader of the operational unit as this may sit with another staff member of the provider organisation.	Modifications have been made to the wording.
2.6	The head of the operational unit in the provider organisation may not have responsibility and autonomy to secure and be accountable for financial and other resources.	No change made.
3.1	Evidence is required of the appropriate volume of face-to-face hours in ITPs, and should focus on the quality of the experience.	Evidence is not available although anecdotally it appears that face-to-face interactions are valued by interns and constitute valuable learning opportunities. The quality of the experience is certainly critical, but the quantity is also relevant.
3.2	The Standards could benefit from having additional guidance on the use of technology, blended and distant learning as a way of fostering innovation in education delivery.	This guidance would be appropriately included in the Evidence Guide.
3.3	Add 'professional organisations' as a separate category of stakeholder.	'Other' key stakeholders as determined by the education provider are now included.
3.4	It was suggested that the Criterion 3.4 specifically include a strength-based focus on indigenous peoples and cultures (Aboriginal and Torres Strait Islander peoples and cultures within Australia and Māori people and culture – Māoritanga - within New Zealand), cultural safety, and exploration of institutional/population-level systems and structural determinants that maintain health inequities. Program design, content and delivery highlights evidence of successful initiatives to improve health outcomes of Aboriginal and Torres Strait Islander people (Australia) and Māori people (New Zealand).	Given the significant input into the wording of this criterion from Aboriginal/Māori members of the Reference Group no further changes have been made. The support for the current wording in the consultation responses was strong. Some of the proposed criterion is not achievable – for example that which is highlighted.

3.8	It was suggested that the wording of the notes reflect the onus on the provider to create opportunities for participation in collaborative IPP.	The Criterion is clear that the program must include opportunities for IPE/IPP and thus it implies strongly that the provider is responsible for providing them. No additional benefit appears to accrue from requiring education providers to create them, particularly if this results in artificial or superficial activities.
4.1	It was suggested that selection criteria require assessment of the suitability of an applicant for participating in a patient-facing profession.	This requirement is currently part of the revised GPhC standards but is considered as not feasible for Australia/NZ providers. There is nothing preventing an individual provider from using additional selection criteria or assessments.
4.2	It was suggested that all information pertaining to a program is available to the regulator on request.	It would be expected that the regulator can mandate this so it is not necessary to include specifically in the Standards.
4.4-4.7	These criteria are potentially duplicated in other Standards.	This is possible but is mitigated by the provision to use the same evidence as evidence of compliance with multiple criteria. It is considered necessary to articulate these criteria explicitly.
4.6	A belief was expressed that this criterion needs to be strengthened, particularly to ensure separation of the employee and the ITP. It was expressed that a conflict of interest and significant risk to the intern exist if the employer is also the ITP provider. This separation is required for the benefit of the interns' wellbeing, protection and development.	Modifications have been made to the wording.
4.6	This criterion needs to further define the role of the ITP provider in managing conflicts between an intern and their employer, particularly if an employer is also the ITP provider.	If the employer were also to be the ITP provider, this would constitute an actual conflict of interest.
5.2	The notes could be expanded to increase clarity.	This could be addressed in the Evidence Guide.
5.2	It was suggested that the notes include psychometric evaluation of the reliability of assessments.	No change made as this is considered overly prescriptive and not feasible.
5.4-5.6	One respondent questioned the specification of individualised feedback on all assessments, suggesting it would place an unmanageable burden on staff.	The current wording does not specify this as a requirement.

Next steps

The feedback from consultation phase 2 will be used to refine the draft Accreditation Standards and to inform the development of the Performance Outcomes Framework and Evidence Guide.

The refined Accreditation Standards will be reviewed by the project Reference Group and Governance Committee, for submission to the Board of APC for endorsement. The endorsed Accreditation Standards will be submitted to the PharmBA by 30 June 2019 for approval.

The draft Performance Outcomes Framework will be published in May 2019, and feedback will be sought through face-to-face consultation sessions and written responses.

Development of the Evidence Guide will be undertaken following approval of the Accreditation Standards by the PharmBA.