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Executive summary

This report was commissioned by the Pharmacy Practitioner Development Committee (PPDC). It examines background research and consultation findings on competency framework models, as well as competency standards to reflect contemporary practice and emerging and future role for pharmacists.

Recommendations are provided to inform the PPDC review of the National Competency Standards Framework for Pharmacists in Australia, and are summarised below.

Goal 1. A competency framework model that is structured in a way that meets the needs of all users.

Recommendations:

1. Structure the framework to support alignment across the many purposes for which the framework is used. (Pages 12, 33, 36, 47, 51)
2. Describe competencies in terms of observable behaviours. (Page 36)
3. Retain only markers of good behaviour in the competency framework, not markers of poor. (Page 39)
4. Retain grouping competencies according to domains (areas of professional responsibility). (Page 42)
5. Initiate discussions with other healthcare professions with a medium to long-term goal of developing a common structure and consistent terminology for the competency frameworks of all healthcare professions. (Page 54)
6. Achieve effective implementation by developing a whole-of-profession communication and implementation plan. (Page 60)

Goal 2. A framework that is focused and organised around the health needs and expectations of people and communities

Recommendations:

7. Give greater prominence to people-centred care. (Page 80)
8. Reflect the pharmacist’s contribution to patient or community outcomes without regard for context and setting. (Page 80)

Goal 3. Competencies for contemporary and future pharmacy practice

Recommendations: (Page 81)

9. Review the management and leadership competencies (Domain 3).
10. Review the education and research competencies (Domain 8).
11. Incorporate competencies required for roles/services being undertaken outside a workplace setting, e.g. self-safety, patients’ cultural safety and mental health.
12. Incorporate competencies required for health management independent of the use of medicines, e.g. for self and patient physical comfort during screening, monitoring and administration services.
13. Ensure observable behaviours for all competencies reflect changing technology (both self-use and patient use).
14. Ensure observable behaviours for all competencies describe the pharmacist as an active member in a healthcare team with responsibility and accountability.
Background

The Pharmacy Practitioner Development Committee (PPDC), chaired by Dr Shane Jackson, is a profession-wide collaborative forum of eleven organisations established to focus on the development of pharmacist practitioners in Australia through consideration of competencies and scopes of practice. The PPDC has commenced a review of the National competency standards framework for pharmacists in Australia which is consistent with its regular review cycle.

In October 2014, the Australian Healthcare and Hospitals Association (AHHA) was appointed to conduct the initial background research and consultation work to inform the PPDC’s subsequent stages of the review.

The AHHA team is shown below.

<table>
<thead>
<tr>
<th>Team member</th>
<th>Project role</th>
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<tbody>
<tr>
<td>Alison Verhoeven</td>
<td>Executive oversight</td>
</tr>
<tr>
<td>Andrew McAuliffe</td>
<td>Consultation survey design, data analysis</td>
</tr>
<tr>
<td>Bryan Stevens</td>
<td>Project sponsor, stakeholder consultation, reporting</td>
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<tr>
<td>Kylie Woolcock</td>
<td>Literature review, research and data analysis, stakeholder consultation, reporting</td>
</tr>
<tr>
<td>Yasmin Birchall</td>
<td>Project management</td>
</tr>
</tbody>
</table>

The project phases underpinning the research and consultation process are described below.

Review of competency frameworks

In the first phase of the project, competency frameworks developed for the professions listed in Appendix 1 was undertaken to compare and contrast their features. The literature review was primarily based on grey literature sourced directly from the relevant organisations. Current versions of documents were reviewed; these were mostly developed in the past 5 years, although some were older.

Competency frameworks were reviewed for Australian professions regulated under the Health Practitioner National Law Act, as in force in each State and Territory, and for pharmacists in Canada, Ireland, New Zealand, the United Kingdom and the United States. The competency frameworks for other professions (health and non-health) were included in the review if the framework:

- included unique features not apparent in other frameworks being reviewed and/or
- was being used for a specific purpose or combination of purposes that was not apparent in other frameworks being reviewed.

A review of the literature for the concepts/rationale supporting different features within these frameworks, as well as for current trends was then undertaken.
Consultation paper

Following the review of competency frameworks, a consultation paper was developed to facilitate consideration of:

- the value and appropriateness of different features of competency framework models in the current competency standards landscape, as they relate to the different purposes for which competency frameworks are used, and as they apply to the pharmacy profession in Australia; and
- competency standards that reflect contemporary practice and emerging and future role for pharmacists.

The questions included within the consultation paper were the basis for discussion and input through an online survey, telephone interviews, stakeholder forums and private independent written submissions.

Stakeholder consultation

The aim of the stakeholder consultation phase was to assist in validating the findings of the data collection and analysis, summarised in the consultation paper, so as to provide a more detailed context to these desktop processes.

The stakeholder consultation process was underpinned by the stakeholder consultation plan, which outlined the process and management tools for the engagement of stakeholders identified by the PPDC in order to facilitate input of their views into the review. It involved stakeholder surveys, stakeholder forums, trade display, telephone interviews and written submissions, as described in detail below. The consolidated feedback for surveys, summaries from the forums and written submissions have been provided as attachments to this report.

Stakeholder surveys

An online survey using specific questions from the consultation paper was developed by the project team and approved by the PPDC. Separate versions of the survey were created to reflect the target audiences.

Electronic versions of the surveys are available through the following links hosted on the AHHA homepage:

Survey for Individual Pharmacists
Survey for Pharmacy Organisations
Survey for Non-pharmacy Organisations or Individuals

An invitation to provide feedback on the pharmacy standards via this survey was emailed to relevant stakeholders in December 2014. The survey was fully online, and remained open until 30 January 2015, via a link on the Australian Healthcare and Hospitals Association website at ahha.asn.au.

The survey was designed to obtain respondents’ views on the value and appropriateness of features of competency framework models in the current competency standards landscape, as they relate to the different purposes for which competency frameworks are used, and as they apply to the pharmacy profession in Australia.

Demographic and practitioner profile data was collected as part of the process, to support stratification of responses enabling identification of themes and issues common to sub-groups of respondents. As common questions were posed for each section, the structure of the online survey was designed to allow respondents to select at the outset only the sections relevant to their response, minimising repetition.
Survey emails

Emails were sent to a total of 419 recipients requesting input to the review of National Competency Standards Framework for Pharmacists by way of participation in a survey.

Subject line: “Your input sought for review of National Competency Standards Framework for Pharmacists”

The key stakeholder groups which received an invitation to complete the survey are:

Accredited Intern Programs
Accredited Pharmacy Schools
Additional stakeholders with business/HR expertise
Aged Care Organisations
Clinical peak bodies and professional colleges
Consumer groups
Consumers via major patient support bodies
International
Other Health Professions – HPAC members
Other organisations
Pharmacy CPD Providers
PPDC member organisations
Private Health Insurers
State/territory health departments

The representative groups that received each of the email types are summarised below:

Pharmacy Organisations 180
Accredited Intern Programs 7
Accredited Pharmacy Schools 20
International 4
Pharmacy CPD Providers 4
Public Hospitals (attention Head Pharmacist) 145

Non-Pharmacy Health Organisations and Individuals 239
Additional Stakeholders with Business/HR Expertise 5
Aged Care Organisations 3
Clinical Peak Bodies and Professional Colleges 25
Consumer Groups and Consumers via Major Patient Support Bodies 8
Health Professionals Accreditation Council Members 11
Local Hospital Networks and Medicare Locals 176
Other Organisations 3
Private Health Insurers 8

Delivery failed for only 11 of the attempted 419 emails (10 x Public Hospitals and 1 x Pharmacy CPD Provider), which is considered a low failure rate for survey databases.

Each target group received a slightly different email message with the link to the appropriate survey. The email texts are shown below.
Target – Individual pharmacists

A review of the National Competency Standards Framework for Pharmacists in Australia has commenced and we would value your response to a brief online survey.

The competency framework impacts you and your role in diverse ways. It is used for:

- Regulation of individual practitioners and health service provision;
- The development and delivery of education leading to initial registration;
- The development and delivery of assessments and examinations (local and overseas trained practitioners);
- Facilitating continuing professional development;
- Human resources and personnel development in the workplace; and
- Articulating community expectations and facilitating policy reform.

While you may not have extensive experience with the current competency framework for pharmacists in Australia, your perspective is unique and important.

Please click on this link to respond to this brief online survey.

Target – Non-pharmacy organisations

A review of the National Competency Standards Framework for Pharmacists in Australia has commenced and we would value your response to a brief online survey.

The review is being undertaken as part of a regular review cycle initiated by the Pharmacy Practitioner Development Committee (PPDC). The PPDC, chaired by Dr Shane Jackson, is a profession-wide collaborative forum of eleven organisations established to focus on the development of pharmacist practitioners in Australia through consideration of competencies and scopes of practice.

The Australian Healthcare and Hospitals Association (AHHA) has been appointed to conduct the initial background research and consultation work which will inform the PPDC’s subsequent stages of the review.

Competency frameworks impact on health professionals in diverse ways. They are used for:

- Regulation of individual practitioners and health service provision;
- The development and delivery of education;
- The development and delivery of assessments and examinations (local and overseas trained practitioners);
- Facilitating continuing professional development;
- Human resources and personnel development in the workplace; and
- Articulating community expectations and facilitating policy reform.

While you may not have extensive experience with the current competency framework for pharmacists in Australia, your perspective is unique and important.

Please click on this link to respond to this brief online survey.
Target – Pharmacy organisations

A review of the *National Competency Standards Framework for Pharmacists in Australia* has commenced and we would value your response to a brief online survey.

The review is being undertaken as part of a regular review cycle initiated by the Pharmacy Practitioner Development Committee (PPDC). The PPDC, chaired by Dr Shane Jackson, is a profession-wide collaborative forum of eleven organisations established to focus on the development of pharmacist practitioners in Australia through consideration of competencies and scopes of practice.

The Australian Healthcare and Hospitals Association (AHHA) has been appointed to conduct the initial background research and consultation work which will inform the PPDC’s subsequent stages of the review.

A [consultation paper](#) has been prepared by the project team, and agreed to by the PPDC. The intent of the paper is to facilitate consideration of the value and appropriateness of different features of competency framework models in the current competency standards landscape, as they relate to the different purposes for which competency frameworks are used, and as they apply to the pharmacy profession in Australia.

The competency framework impacts the role of the pharmacist in diverse ways. It is used for:

- Regulation of individual practitioners and health service provision;
- The development and delivery of education leading to initial registration;
- The development and delivery of assessments and examinations (local and overseas trained practitioners);
- Facilitating continuing professional development;
- Human resources and personnel development in the workplace; and
- Articulating community expectations and facilitating policy reform.

Your perspectives about the design and content of the current competency framework for pharmacists in Australia are unique and important.

Please click on this [link](#) to full survey to respond to the survey.

Stakeholder forums

Two stakeholder forums were conducted as part of the project, to allow key stakeholders to provide additional feedback. The forums were in the form of plenary sessions, with facilitated, structured discussion to maximise engagement and feedback to be captured. After a brief introduction, the plenary sessions were built around questions from the relevant sections of the consultation paper, and informed by the responses from the online survey. Each forum was restricted to manageable numbers of approximately 30 key stakeholders to allow for small group discussions prior to consolidating responses.

The details are summarised on the following page.
The format for each forum is shown below.

**Forum running sheet**

**Introductions**

Welcome and project overview

Introduction of project team and audience introductions

**The context of the pharmacy competency standards**

Overview of the current environment – the current competencies for pharmacists in Australia (including the National Competency Standards Framework and the Advanced Pharmacy Practice Framework); how competencies are currently being used

Brief comments from audience

**The structure of the pharmacy competency standards**

Presentation: Overview of literature review

Questions/open discussion based on directed questions, and responses to survey

**The content of the pharmacy competency standards**

Presentation; as for previous section

Framework tick sheet activity and group discussion

Discussion

**Summary/conclusion**

Summary of discussion; next steps for project

Thank you; next steps for PPDC
Trade display

The AHHA was offered the opportunity to host a display at the National Australian Pharmacy Students Association Congress trade show on 28 February 2015. This allowed for additional consultation with stakeholders, promotion of the survey, and distribution of relevant materials to a broad range of pharmacy stakeholders who were in attendance.

Telephone interviews

One on one telephone interviews were offered to a small number of key opinion leaders nominated by the PPDC.

The purpose of these interviews was to validate survey responses, clarify input, and build on themes that were valuable to the project.

One key opinion leader accepted the invitation for a telephone interview and this was conducted on 5 February 2015.

Written submissions

Written submissions from individuals and organisations wishing to provide additional feedback during the consultation period were welcomed. Written submissions were received from the Australian Council of Anaesthetists, Optometry Australia, Pharmacy Council of NSW and Speech Pathology Australia.

Final report

This report has been prepared to provide the findings of the background research, literature review, and stakeholder consultation, including:

- comparisons of other health professional competency standards to the current Australian pharmacist competency standards; and
- an assessment of changes and advances in the health competency standards arena including identification of innovative approaches to competency standards development or setting, and comment on their applicability to the Australian pharmacy profession.

Recommendations are provided in relation to:

- the type of competencies that need to be included in the pharmacist competency standards to appropriately reflect contemporary practice and likely future changes to pharmacy practice in Australia; and
- medium to long term planning of future competency standards models for the Australian pharmacy profession and whether these require incremental change or a substantial restructure.
The report has been structured as follows:

Part 1. Purpose and use of the competency framework

This part provides context for the following parts, describing the current purposes and uses for the current competency standards framework.

Part 2. The competency framework model

This part provides a discussion on the value and appropriateness of different features of competency framework models. Recommendations are provided in relation to each feature.

Part 3. Competency standards to reflect contemporary practice and emerging and future roles.

This part provides a discussion on contemporary practice and emerging and future roles for pharmacists. Recommendations are provided in relation to the types of competency standards that should be included.

Part 4. Goals and recommendations

A consolidated list of goals and recommendations is provided at the end of the report.
1. Purpose and use of the competency framework

1.1 Overview

Background research

There are increasing efforts to define professional competence within all health professions including in areas of specialty, extended and advanced practice, and for interprofessional collaboration. Competency frameworks are being used for diverse purposes, such as for:

- Regulation of individual practitioners and health service provision
- The development and delivery of education leading to initial registration
- The development and delivery of assessments and examinations (local and overseas trained practitioners)
- Facilitating continuing professional development
- Human resources and personnel development in the workplace
- Articulating community expectations and facilitating policy reform.

There are clear benefits to defining scope of practice and identifying appropriate indicators of performance. However, there are still concerns expressed in the literature that:

- The competency approach has a ‘tendency to limit the reflection, intuition, experience and higher order competence necessary for expert, holistic or well developed practice’\(^1\)
- The implementation of the numerous competency frameworks currently being produced across practice settings and from various sources raises a number of practical challenges,\(^2\) including for the individual who is required to declare maintenance of competence for their scope of practice
- The creation of competency frameworks by professional experts and leaders can reinforce conventional discourses about professional norms, behaviours and attitudes, and perpetuate existing domains of professional legitimacy\(^2\)
- Patient centred care and collaborative practice is adversely impacted when competency frameworks are used to limit activities and roles to certain professions.\(^2\) Increased inter-sectoral alignment is recommended so that whole of health workforce developments maximise the potential for shared learning pathways, recognition of prior learning and articulation agreements.\(^3\)

The topic is complex and dynamic, and the ongoing scale and validity of such concerns are unclear. It is important to be aware that there is substantial variation in the competency framework models that exist, which is unsurprising given the multiple contexts in which they are used. Various competency frameworks, underpinned by different definitions and concepts, have been developed to address the current and perceived future needs of the respective professions at the particular time, as well as those who are to use them. Multi-dimensional frameworks have been adopted by many professions in recent years, with features intended to address concerns raised.

Consultation feedback

From the feedback provided during the consultation, it was apparent that the current competency framework for pharmacists in Australia is being used for the full range of purposes listed above.
Respondents to the online survey were asked to provide information about their use of the current competency framework. This has allowed consideration of whether support for different features is influenced by the purpose for which the framework is being used.

Pharmacy organisations were also asked to indicate the value of a competency framework when used for the different purposes. The responses are reflected in Figure 1.

Figure 1. The perceived value of a competency framework when used for different purposes in pharmacy in Australia

While the value of a competency framework appears to be greatest when used for education and assessment leading to registration, its value across all of the purposes was high. Given this, it is important to consider how the competency framework is used for each of these purposes. This was further emphasised in the consultation forums, with feedback that there needs to be agreement about how the different users will use the framework before investing in making changes.

**Recommendation 1.** Structure the framework to support alignment across the many purposes for which the framework is used.
1.2 Competencies in regulation

Background research

To regulate is ‘to control, govern or direct, especially by means of regulations or restrictions’.⁴ Historically, laws to define scopes of practice for professions and the performance of defined functions were introduced to protect the public from potentially harmful health services being provided by unqualified people. As such, they:⁵

- Defined the practice of the profession in question
- Limited that practice to people who satisfactorily complete a specified training and examination requirements
- Restricted professional titles or credentials and the performance of defined functions to those licensed in that profession.

However, such laws can also limit a profession’s ability to contribute positively to health care. These limitations may be a result of not only the defined scope of practice for one’s own profession, but by the scopes defined for other professions or functions as well.

Approaches to regulating both professions and the performance of defined functions through defined scopes of practice vary (sometimes quite significantly) between different jurisdictions, between professions within jurisdictions, and with time.

Regulation of pharmacists and their scope of practice

Within Australia’s health system, there is a complex network of governance and support mechanisms that enable the policy, legislation, coordination, regulation and funding aspects of delivering quality services. It is a joint responsibility of all levels of government, with the planning and delivery of services being shared between government and non-government sectors.⁶ As such, regulation occurs at a number of levels and is influenced by a number of sources (including the individual’s self-regulation), restricting a pharmacist’s potential individual scope of practice.

Figure 2 depicts in a simplified manner the regulation (or restriction) that occurs at a number of levels, from the pharmacy profession’s scope of practice as reflected by the Pharmacy Board of Australia definition of practice, being:

‘any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. ... practice is not restricted to the provision of direct clinical care. It also includes working in a direct nonclinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession and/or use their professional skills’⁷

to the individual pharmacist’s 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’.⁸
Current use of the competency framework to regulate scopes of practice

In Australia, pharmacists are regulated under the Health Practitioner Regulation National Law Act⁹ (the National Law), as in force in each State and Territory. The Pharmacy Board of Australia (PBA) has been established for the pharmacy profession and has the functions defined in the National Law. The Australian Pharmacy Council (APC) exercises the accreditation functions defined in the National Law for the pharmacy profession.

The National Registration and Accreditation Scheme (NRAS), established as an object of this Law, has the objectives listed in Table 1. The National Competency Standards Framework for Pharmacists in Australia (the ‘Competency Framework’) for the pharmacy profession underpins activities that contribute to most of these objectives.

This Section focuses on those regulatory activities relating to objectives a. and e. (with the other activities being covered in later Sections).
### Table 1. The application of the competency framework in achieving the objectives of the National Registration and Accreditation Scheme

<table>
<thead>
<tr>
<th>Objectives of the National Registration and Accreditation Scheme</th>
<th>Examples of the application of the competency framework towards achieving these objectives</th>
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</table>
| a. To provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered | While not explicitly stated (e.g. in a Registration Standard), the Competency Framework is used by the PBA to indicate the scope of practice for the profession  
- The PBA and the APC use the Competency Framework in the development of exams for determining eligibility for registration  
- The Competency Framework may be used as a reference point in investigating, assessing or responding to notifications/complaints about the performance or conduct of a pharmacist |
| b. To facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction | None identified |
| c. To facilitate the provision of high quality education and training of health practitioners | Education providers (universities and intern training program providers) design and develop curriculum with regard to the Competency Framework  
- The APC accredits programs that (in meeting the relevant Accreditation Standards) can demonstrate students or interns achieve the required competencies in the Competency Framework |
| d. To facilitate the rigorous and responsive assessment of overseas-trained health practitioners | The APC designs and develops the assessments and examinations to determine whether overseas-trained pharmacists can demonstrate the required competencies in the Competency Framework |
| e. To facilitate access to services provided by health practitioners in accordance with the public interest | The Competency Framework has been used to demonstrate services that are within the pharmacy profession’s scope of practice (i.e. pharmacist vaccination) |
| f. To enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners | The Competency Framework can be used to guide continuing professional development (CPD) of individuals  
- The Competency Framework provides a mechanism for employers, the profession (collectively through associations and individually) and policy makers to consider how the pharmacy profession can meet the current and future health needs of the community |
The National Law, however, is not the only legislation governing a pharmacist’s scope of practice. The federal system of government in Australia involves six states, two territories and the federal government, each with law-making functions. Through federal and state/territory government there is regulation of other legal and professional obligations (e.g. healthcare complaints, privacy, confidentiality, consent, safe and quality pharmaceuticals and therapeutic goods, access to pharmaceuticals, funding of services, pharmacy ownership, employment practices), where the competency framework may also be applied.

One example involves the National Health Act 1953 (the Act), which allows for payment of a claim for the supply of a pharmaceutical benefit only where the supply has been made at or from premises for which the pharmacist is approved under the Act. The National Health (Pharmaceutical Benefits) (Conditions of approval for approved pharmacists) Amendment (Supply from Premises) Determination 2014 specifies that approved pharmacists must maintain currency of their pharmaceutical knowledge in accordance with the Competency Framework.10

Another example involves the requirements by which pharmacists participate as a service provider in the Home Medicines Review (HMR) program, funded by the Australian Government Department of Health as part of the Fifth Community Pharmacy Agreement, including abiding by the SCPA General Terms and Conditions and HMR Program Specific Guidelines.11 The Accredited Pharmacist who is approved to conduct the HMR Service is required to be Medication Management Review accredited through the Australian Association of Consultant Pharmacy (AACP) or Society of Hospital Pharmacists of Australia (SHPA).

The AACP accreditation process has been designed to identify pharmacists with the required competencies to provide a particular professional service to the required level, and uses a Competency Map12 that selects those competencies from the Competency Framework that are required to practice in the area of medication reviews.

State and Territory Health Departments also have governance frameworks to regulate advanced and extended scope of practice roles (including through credentialing or privileging) for health professionals employed by that department across a diverse range of sectors, contexts and settings. While these governance frameworks differ between states and territories; the concepts of assessing competence and/or performance (and frameworks to define these) are generally discussed.

Consultation feedback
Consultation feedback confirmed that the current competency framework for pharmacists in Australia is being used for regulation. Specific examples of uses provided in the online survey included:

- Development and implementation of documentation to regulate pharmacists
- The regulation of pharmacists’ scopes of practice, e.g. for administering vaccinations, in determining eligibility for credentialing as a Diabetes Educator
- To facilitate objective performance assessments and subsequent action (including to support remediation), noting that other resources are also required in this process, as well as contextualisation for the individual pharmacist.
1.3 Competencies in education and assessment leading to initial registration

Background research

To be eligible to apply for general registration as a pharmacist with the Pharmacy Board of Australia, one must either:\n
- Graduate from an approved program of study in Australia or New Zealand, and then complete a period of supervised practice while completing an intern training program. The Australian Pharmacy Council (APC) is the accreditation authority responsible for accrediting education providers and programs of study for the pharmacy profession.

- Graduate from a pharmacy course conducted by an overseas course provider (provided that the qualification has been accepted by the APC as being comparable to Australia pharmacy qualifications), meet the eligibility requirements and complete the relevant examinations, and complete a period of supervised practice while completing an intern training program.

Accreditation of education providers and programs of study

Accreditation is an important quality assurance and quality improvement mechanism for health practitioner education and training.\(^{15}\) For professions regulated under the Health Practitioner Regulation National Law Act\(^{9}\) (the National Law), as in force in each State and Territory, the National Registration and Accreditation Scheme (NRAS) established a common statutory framework for accreditation bodies that had previously operated within a diversity of profession-specific models.\(^{15}\) For professions not regulated under the National Law (both health and non-health), accreditation occurs under other regulatory models (including self-regulatory or co-regulatory).

Accreditation Standards are used to assess whether a program of study, and the education provider that provides the program of study, provides graduates of the program with the knowledge, skills and professional attributes to practise the relevant profession in that jurisdiction.\(^{15}\)

In terms of curriculum development, the Accreditation Standards for every profession make reference to educational outcomes, be they competencies, graduate/learning outcomes and/or graduate/professional attributes. These outcomes may be integrated within the Accreditation Standards document, included as an appendix to the document, or referred to but only available as a separate document.

Variation in how educational outcomes are defined for professions appears to be largely influenced by whether graduates of the program are immediately eligible to register/practise in the relevant profession or whether there are additional requirements before being eligible for general registration. In Australia, most professions regulated under the National Law are eligible to register on graduation. As such, the learning outcomes for the program should at least be equivalent to the competencies defined for an entry level practitioner.\(^{16}\) Minimum threshold learning outcomes (TLOs) common across healthcare graduates at professional entry-level have been developed, and are also a key document in this regard.\(^{17}\)

However, for some professions there are various ‘milestones’ occurring post-graduation along a trajectory towards competence, e.g. professional/workplace experience, professional/workplace assessments, portfolios and examinations. At each ‘milestone’, there may be different outcome measures, which may or may not be explicitly linked to the competencies or each other.
Assessment of overseas trained practitioners

The assessment of overseas trained health professionals who wish to practise in Australia is undertaken by the accreditation authority or professional association for that profession. For registration purposes, this function is assigned by the respective National Board under the National Law. For migration purposes (e.g. Skilled Migration and Temporary Activity visa programs), this function is specified by the Minister for Immigration and Border Protection.

The assessments undertaken by these bodies vary depending on:¹⁸

- The competencies or capabilities specified for that profession
- The methods of assessment chosen.

Competency frameworks are reported to be used to support the assessment of overseas trained practitioners by facilitating such things as:

- Consideration of equivalence of qualifications awarded by overseas institutions with those awarded by accredited Australian programs;
- Consideration of equivalence of accrediting bodies in overseas jurisdictions with those in Australia; and
- Development of assessment blueprints and tools/exams for assessing overseas trained practitioners.

For the health professions regulated under the National Law, some competency frameworks explicitly state that supporting the assessment of overseas trained practitioners is a key function. However, it is often not specifically identified within the competency framework how they have been (or are being) used.

Current use of the competency framework in education and assessment leading to initial registration of pharmacists

Of the health professions regulated under the National Law in Australia, medicine and pharmacy have additional education and training requirements after graduation from an approved program of study in order for graduates to be eligible to register. As such, the determination of ‘outcome milestones’ along the pathway towards being deemed competent needs broader and coordinated consideration.

For initial registration as a pharmacist, successful completion of an approved pharmacy degree program, internship (involving a period of supervised practice and accredited intern training program), and written and oral examinations is required. ‘Outcome milestones’ are referenced through this process in the following ways:

- The Accreditation Standards for Pharmacy Programs require pharmacy degree programs to produce ‘graduates who have the graduate attributes of the University and the knowledge, skills and attitudes necessary to commence supervised practice as an intern pharmacist’.²⁰ Recently, a collaborative initiative with representatives from pharmacy schools in Australia has developed nationally agreed Pharmacy Learning Outcomes (PhLOs) for students graduating from entry-level pharmacy programs, clarifying expectations of both standards and levels of achievements across programs in Australia.²¹ The potential for mapping curricula to PhLOs in accreditation requirements is currently under consideration by APC.
The Accreditation Standards for Australian Pharmacy Intern Training Programs (ITP) require ITP providers to ‘provide learning opportunities that enable interns to integrate and apply the defined functional areas, not including supplementary elements, of the current Competency Standards for Pharmacists in Australia’.  

While the entry-level competencies are to be met at entry to professional practice, they can serve as a source of guidance to the teaching and learning expected across both the pharmacy degree program and the intern training program. In this regard, the Customised Entry-level Competency Tool for Pharmacists was developed to assist with identifying the contributions of pharmacy programs and intern training programs to the learning and development of students and intern pharmacists, respectively.

The Intern Written Examination Guide states that this assessment is based upon Domains 1, 4, 5, 6 and 7 of the National Competency Standards Framework for Pharmacists in Australia.

The Pharmacy Oral Examination (Practice) Candidate Guide states that the Pharmacy Board of Australia has adopted the National Competency Standards Framework for Pharmacists in Australia as a framework for the oral examination (practice).

For overseas trained pharmacists, the assessment of qualifications and skills for the purposes of registration and migration is undertaken by the APC. Various steps in the assessment process are guided by the competencies, e.g.:

- To inform an accelerated process for assessing overseas qualified pharmacists (‘Stream B’), the APC uses a comparison of competencies (or equivalent) required for pharmacy practice in other countries. However, in addition to competencies, the accreditation standards, examinations and clinical placement activity; registration standards; pharmacy practice standards and practice environment are also compared. Standards to underpin this process have been developed and approved by the Pharmacy Board of Australia.

- The Competency Assessment of Overseas Pharmacists (CAOP) is an examination designed to assess competence relative to the present day practice of pharmacy in Australia as defined in the National Competency Standards Framework for Pharmacists in Australia.

Consultation feedback

Consultation feedback confirmed that the current competency framework for pharmacists in Australia is being used for education leading to initial registration. Specific examples of uses provided in the online survey included:

- Designing curriculum, content, and assessment activities for university and intern training programs
- As a reference and assessment tool for supervisors of student placements
- As a reference and assessment tool for students when on placements (i.e. for gathering evidence to demonstrate achievement of competencies)
- In establishing and applying for accreditation
- As a background framework, to guide more specific activities.

There was no specific consultation feedback regarding the use of the current competency framework for pharmacists in Australia for the assessment of overseas trained practitioners.
1.4 Competencies for ongoing professional development of pharmacists

Background research

Competency frameworks are reported to be commonly used for the continuing professional development (CPD) of health care professionals, introduced largely due to little formal structure to development post-registration. For the health professions regulated under the National Law, registration standards have been developed by each National Board that specify requirements for CPD. For most professions this involves completing a set number of hours of CPD activities, and for some, reflective elements including descriptions of how the activities relate to professional practice and whether desired outcomes have been achieved. However, reference to the respective competency framework in registration standards is only made by:

- The Nurse and Midwifery Board of Australia, with a requirement that for self-directed CPD, learning needs are identified and prioritised based on an evaluation of their practice against the relevant competency or professional practice standards;
- The Pharmacy Board of Australia, with a requirement that pharmacists are expected to self-assess their individual needs with reference to the Competency Standards for Pharmacists in Australia.

The limited reference to competency frameworks for the purpose of CPD appears consistent with the stated purpose of competency frameworks that exist for the respective professions, with professional development generally not an explicit purpose for frameworks developed for the professions regulated under the National Law. Most of these frameworks focus on the competencies of entry level practitioners only.

Current use of the competency framework in the accreditation of CPD for pharmacists

As specified in the Pharmacy Board of Australia (PBA)’s CPD registration standard, CPD can be either accredited or non-accredited. The accreditation of CPD activities provides assurance to pharmacists that an activity has been reviewed for its educational quality and for its relevance to a pharmacist’s practice. However, at this time, the PBA has not stipulated that a proportion of CPD activities must be accredited.

The Australian Pharmacy Council (APC) has been authorised by the PBA to accredit providers of pharmacy CPD activities. The APC does this by accrediting organisations that meet criteria to accredit CPD on APC’s behalf. CPD accrediting organisations assess CPD activities against the Accreditation Standards for Continuing Professional Development Activities. These Standards specify that the National Competency Standards Framework for Pharmacists in Australia must be appropriately considered in the development of content and materials for CPD activities, and they must have a statement of specific learning objectives that are mapped to these competency standards. Organisations currently accredited to accredit CPD for pharmacists are the Australian College of Pharmacy, Pharmacy Guild of Australia, Pharmaceutical Society of Australia, and the Society of Hospital Pharmacists of Australia.
Consultation feedback

Consultation feedback confirmed that the current competency framework for pharmacists in Australia is being used for the ongoing professional development of pharmacists, although the extent varied substantially between organisations that provide and accredit CPD and individual practitioners. Respondents to the online survey were asked the question ‘In the past 5 years, have you used the competency framework in the context of ongoing professional development?’ Table 2 reflects the responses.

Table 2. Use of the competency framework for ongoing professional development

<table>
<thead>
<tr>
<th>In the past 5 years, have you used the competency framework in the context of ongoing professional development?</th>
<th>Pharmacy Organisations</th>
<th>Individual practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>70% (7)</td>
<td>38% (35)</td>
</tr>
<tr>
<td>Only in a limited way</td>
<td>20% (2)</td>
<td>44% (41)</td>
</tr>
<tr>
<td>No</td>
<td>10% (1)</td>
<td>18% (17)</td>
</tr>
</tbody>
</table>

Pharmacy organisations responding in the online survey provided the following specific examples of uses of the competency framework:

- Evaluating the CPD needs of pharmacists in different practice settings
- Developing CPD programs
- Assessing CPD education activities to ensure relevance to pharmacy practice in Australia for accreditation
- Adapting internationally-developed CPD activities for delivery in Australia
- Setting a framework for individual CPD plans
- Development, implementation and use of SHPA ClinCAT
- Development of competency statements for advanced practice.

Individual practitioners responding in the online survey identified the following examples of uses of the competency framework:

- Personal assessment and development (12)
- Education/training development (9)
- Staff development (7)
- As a student (4)
- For accreditation (2).
Reasons provided by individual practitioners for having limited to no use of the current competency framework are listed in Figure 3.

Figure 3. Individual practitioner reasons for having limited to no use of the current competency framework

*Totals to more than 100% as multiple reasons possible

General recommendations provided by respondents to the survey to make the competency framework more useful to individual practitioners relate to both structure and content, and are listed in Figure 4. The level of detail was reported to both facilitate and hinder use of the framework. One respondent stated ‘the level of detail provides greater specificity of acceptable outcomes; without this, the outcomes become generic and potentially meaningless as each individual may interpret them differently’.

Figure 4. Individual practitioner recommendations for making the competency framework more useful
1.5 Competencies in the workplace

Background

While professional development (particularly for registration purposes) is the responsibility of the individual practitioner, employers also have an interest in the development and advancement of health professionals.

Health service managers have been reported to use competency-based career frameworks for:

- Conducting service reviews
- During workforce planning and development
- Redesigning or defining roles
- During appraisal, self-appraisal and personal development planning
- Conducting reviews of skill mix
- Developing and delivering training programs or qualifications.

Consultation feedback

There was limited consultation feedback regarding the use of the current competency standards framework for pharmacists in Australia in the workplace. Specific examples described by respondents included:

- At interview
- As a performance management tool
- To assist in the disciplinary process of a pharmacist that was not competent and safe.
2. The competency framework model

2.1 Overview

Background research

There is no single ‘correct’ competency framework model. However, there are a number of features apparent in (or being proposed for) more recently developed competency frameworks, including:

1. Defining ‘competent’ as a point on a curve of improving performance
2. No longer breaking down each competency into tasks or activities, but rather, describing competencies in terms of observable behaviours
3. Including markers of poor behaviour
4. Grouping competencies within frameworks according to roles, rather than areas of professional activity
5. Reflecting variations in scopes of practice within frameworks
6. Reflecting the performance continuum in frameworks
7. Increasing the focus on the implementation of frameworks, e.g. by identifying entrustable professional activities.

The concepts/rationale supporting different features within these frameworks is discussed in the following sections. Reviewing the literature around competence, competencies and performance is complicated by the use of varied definitions and underlying concepts. This is no surprise given the multiple contexts in which the terms are used, but important to be cognisant of when considering the applicability of trends to the Australian pharmacy context.

Consultation feedback

Pharmacy organisations and individual practitioners responding to the online survey were asked the overarching question ‘How much change do you think is required to the current competency framework for pharmacists in Australia?’ Figure 5 reflects the responses.

Figure 5. Extent of change required to current competency framework for pharmacists in Australia
While most respondents indicated incremental change is needed, there is still a large proportion who indicated fundamental change is required. The types of change considered to be required varied between respondents.

When considering the competency framework model, the types of changes proposed were generally consistent with trends identified in the background research. These will be considered in detail in the following sections.
2.2 Defining ‘competent’ as a point on a curve of improving performance

Background research

A current model for explaining the relationship between competence and performance is described in the literature by Khan and Ramachandran (2012), as modified from Dreyfus and Dreyfus (1980), Carrachio (2008) and ten Cate et al (2010). This model will be referred to in this paper as the ‘modified Dreyfus model’.

The modified Dreyfus model identifies seven levels of performance along a continuum (Incompetent, Novice, Advanced Beginner, Competent, Proficient, Expert, Mastery), as depicted in Figure 6.

In this model, the relationship between performance and competence is described, where:

- **Performance** is defined as ‘the action or process of performing a task or a function’. In a clinical environment, performance is a complex construct influenced by a multitude of factors (see Figure 7), and it is this combination of factors that makes it a variable trait. Further, the definition implies that every individual is able to perform every skill, even though not necessarily at a level sufficient to be deemed competent.

- **Competence** is defined as ‘an ability to do something successfully or efficiently’. It is a point on the spectrum of improving performance. While common in the English language to use the term ‘competence’ interchangeably with the term ‘competency’, this model reserves the term ‘competency’ to describe ‘the skill’, while ‘competence’ describes the person who is able to perform that competency at a certain level.

In this model, the points at which each level of performance intersects the X- and Y-axes in Figure 6 are arbitrary, varying from person to person and/or competency to competency. Also, the point at which mastery occurs should not be considered absolute, as individuals can continue to improve beyond this level.
In this model, individuals reach the level of ‘competence’ on the spectrum of improving performance predominantly through *training* (defined as a process of acquisition of new skills or components of skills taught by others), while reaching the levels of proficiency, expertise and mastery predominantly through *deliberate practice* (defined as self-directed rehearsal, facilitated or un-facilitated by tutors, but leading to refinement of skills). However, there is no demarcation of a point at which further training would not be of benefit (or before which deliberate practice would not be of benefit) for a particularly competency.

The model allows for attributes, supervision and training requirements, and the level of entrustment to be assigned for each level of performance. An example is provided by Khan and Ramachandran (see Table 3).
### Table 3. Attributes of levels of performance in the context of healthcare – modified from professional standards for conservation, Institute of Conservation (London) 2003, websource²¹

<table>
<thead>
<tr>
<th>Level of Performance</th>
<th>Attributes of performer (looking at overall performance encompassing simple tasks, and routine and non-routine complex tasks)</th>
<th>Supervision or training requirements</th>
<th>Relationship to the level of entrustment as described by ten Cate (2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incompetent</strong></td>
<td>Unable to perform</td>
<td>Training and supervision needed to move up to the novice level</td>
<td>Level I</td>
</tr>
<tr>
<td><strong>Novice</strong></td>
<td>Rules (protocol) based performance</td>
<td>Direct supervision needed at all times</td>
<td>Level I</td>
</tr>
<tr>
<td><strong>Advanced beginner</strong></td>
<td>Guidelines-based performance</td>
<td>Able to perform routine tasks under indirect supervision</td>
<td>Level II, Level I</td>
</tr>
<tr>
<td><strong>Competent</strong></td>
<td>Performance not solely based on rules and guidelines but also on previous experience</td>
<td>Able to perform routine complex tasks and training and supervision needed for non-routine complex tasks</td>
<td>Level III for routine complex tasks, Level II for non-routine complex tasks</td>
</tr>
<tr>
<td><strong>Proficient</strong></td>
<td>Performance mostly based on experience</td>
<td>Still needing supervision for non-routine complex tasks</td>
<td>Level IV for routine complex tasks, Levels III-IV for non-routine complex tasks</td>
</tr>
<tr>
<td><strong>Expert</strong></td>
<td>Performance based on experience and intuition</td>
<td>Able to train and supervise others performing routine and non-routine complex tasks</td>
<td>Level V</td>
</tr>
<tr>
<td><strong>Master</strong></td>
<td>Performance becomes a reflex in most common situations</td>
<td>Able to train other experts at national or international level</td>
<td>Level V</td>
</tr>
</tbody>
</table>
It is important to acknowledge, however, that this model contrasts with a large body of published literature that considers competence and performance as separate domains, e.g. the Cambridge model, where performance is identified as a product of competence combined with the influences of factors related to the individual (e.g. health, relationships) and factors related to the system (e.g. facilities, practice time) (see Figure 8).

**Figure 8. The Cambridge model for delineating performance and competence**

In some models, this has been explained as ‘competence is what we have been trained to do’, while ‘performance is what we actually do in day to day practice’ (see Figure 9).

**Figure 9. The distinction between competence and performance, as consistent with the Cambridge model**
Khan and Ramachandran report that the notion of competence and performance being two separate domains may have been partly created by an over-simplistic application of the principles described by Miller (see Figure 10) to complex assessment tools, where ‘does’ has become performance and ‘shows how’ competence.31

Figure 10. Miller’s Pyramid, as reflected in the modified Dreyfus model

When considering Miller’s pyramid, they argue that both ‘does’ and ‘shows how’ can be classified as performance, the former being actual performance in the workplace and the latter as demonstrated performance for assessment purposes (whether in the workplace or in simulated settings).

In the modified Dreyfus model (and in contrast with the Cambridge model), competence (as a point on the spectrum of improving performance) is also an interplay between the individual and the environment, and as such, will vary as the environment changes.35
Consultation feedback

Respondents to the online survey were asked the extent to which they agreed with the statement that ‘Competent’ should be identified as one level of performance along a continuum from Incompetent through to Mastery (i.e. the modified Dreyfus model). Figure 11 reflects the responses.

Figure 11. Level of agreement that ‘Competent’ should be identified as one level of performance along a continuum from Incompetent to Mastery

Pharmacy community. Pharmacy organisations and individual practitioners responding to the online survey mostly agreed that ‘competent’ be identified as one level of performance along a continuum.

The extent of agreement was greatest for those using the framework in the context of ongoing professional development and in the workplace. This was supported as positively demonstrating that an individual may move along a pathway of continuous improvement throughout their professional life, with practice, training and experience all being linked to improved professional performance. It would facilitate individuals aiming for more than ‘good enough’ as the actual level attained could be recognised, not just ‘Competent’ or ‘Not yet competent’. It would also aid the integration of the Advanced Pharmacy Practice Framework with the competency standards framework.

The views expressed in the online survey were validated by the views expressed during the consultation forums. Students reported value in a framework that showed progression into leadership roles post-registration, while educators reported value in a framework that showed that an advanced level of performance should not be expected at the point of graduation.
Concern expressed about the statement was not so much in relation to disagreement with the concept, but more in relation to how it would be implemented. Respondents to the online survey expressed, both in relation to education leading to initial registration and regulation, that the competency standards need to support assessment of someone as either ‘Competent’ or ‘Not yet competent’, also noting that competence is not a ‘one-off’ assessment but something that needs to be demonstrated on repeated occasions. It was suggested that the levels of performance along the continuum be presented in a separate ‘Performance Framework’, aligned with the ‘Competence Framework’. It was expressed that this would also prevent the document becoming more complex and unwieldy (and being used even less that the current framework).

Concern was also expressed, both in the online survey and consultation forums, about the number of performance levels and the terminology used. While it was expressed that the performance levels would ‘fit neatly’ with what is intended for the profession, the milestones selected and terminology needed further consideration. In general, the term ‘Incompetent’ was not considered to be appropriate.

The notion of capability was raised in the consultation forums. Like with the term competency, a variety of definitions and concepts are used in association with this term in the literature. In some contexts, capability appears to be viewed as a higher level of performance than competence (i.e. that demonstrated by advanced practitioners who embrace complexity as a mode of practice), along a continuum of familiar problems with familiar solutions to less familiar context or problems. In other contexts, a high level of capability is not synonymous with being comprehensively competent. Rather, intelligent judgement, ethical practice and self-efficacy allow an individual to know what level of competence is needed and to exercise it wisely.

A view expressed at a consultation forum was that capability is important as competence tends to ignore time and context. They noted that, while the competency framework doesn’t need to define/encompass capability, it is important to be clear about the difference and reflect that competence is dependent on different contexts. Another view expressed at a consultation forum was to consider the way capability is used in workforce documents, such as Health LEADS and the Medical Radiation framework. Activities are described in a way that assumes the practitioner could be working in a variety of contexts (including unanticipated situations).

**Non-pharmacy organisations.** Non-pharmacy organisations responding to the online survey also mostly agreed that ‘competent’ be identified as one level of performance along a continuum.

The feedback was consistent with that provided by the pharmacy community. Respondents agreed that presenting the pathway to advanced performance as a continuum was valuable. The assessment that occurs at the different performance levels was also raised; the need for ‘competent’ to be a threshold for assessing graduates was expressed, but also the need for advanced performance to be assessed and not just assumed from ‘years since post’.
Recommendation 1. Structure the framework to support alignment across the many purposes for which the framework is used.

- Define ‘competent’ as a point on a curve of improving performance. For any specified competency, ‘competent’ is the level of performance required to be eligible for initial registration as a pharmacist, and/or is the minimum level of performance that must be retained for continuing registration.

- Develop an overarching framework that identifies competencies for varying scopes of practice and supports recognition of varying levels of performance (including for credentialing/privileging processes).

- Agree on those components that are central to all users. Develop a Competence Framework to describe competent performance, while higher levels of performance (the ‘performance continuum’) should be described in an aligning Performance Framework. Guidelines and tools specific to particular users may sit in supporting documents (i.e. for contextualisation and translation).
2.3 Describing competencies in terms of observable behaviours

Background research

Historically, and consistent with the approach taken by many professions, the 2003 version of the competency standards for pharmacists in Australia relied heavily on the format adopted in the Australian National Training Authority (ANTA) Training Package guideline (developed for use in the vocational education and training setting). This approach described professional practice by breaking down complex professional functions into a series of related tasks (Elements), with associated Performance Criteria providing observable behaviours or results, and Evidence Examples provided to assist with interpretation and assessment of performance. The 2010 version of the competency standards built on past efforts, without substantial change to the format previously adopted.38

While such a structure has been reported as useful for supporting the description and measurement of practice,38 it is an approach that has been criticised for understating the inherent integration of tasks and the complex conceptual, analytical and behavioural functions that underpin professional service delivery.

It has also been reported that describing general competencies in detail leads to bulky, fragmented documents that lose practical value.35

It has been reported that if a framework is too complex, ‘it is highly expensive to develop, implement, maintain and assess. Further, it becomes a ‘good tool used badly’, in that it requires so much workplace assessment time that it detracts from time available for patient care.’3

In recent times, a number of professions in Australia and internationally appear to have addressed such criticisms by no longer breaking down each competency into tasks or activities in their competency frameworks, and rather describing observable Behaviours for each competency (as indicators of the expected performance in the workplace). Recent examples include the frameworks for pharmacists in Ireland39 and New Zealand40 (see Figure 12).

Figure 12. Extract from Competence Standards for the Pharmacy Profession in New Zealand40

<table>
<thead>
<tr>
<th>Competency O3.1</th>
<th>Assess prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviours</td>
<td></td>
</tr>
<tr>
<td>O3.1.1</td>
<td>Validates prescriptions ensuring they are authentic, meet all legal and professional requirements and are correctly interpreted</td>
</tr>
<tr>
<td>O3.1.2</td>
<td>Uses a systematic approach to assess and review available patient medical history and medication record or notes</td>
</tr>
<tr>
<td>O3.1.3</td>
<td>Applies knowledge in undertaking a clinical assessment of the prescription to ensure pharmaceutical and therapeutic appropriateness of the treatment and to determine whether any changes in prescribed medicines are warranted</td>
</tr>
<tr>
<td>O3.1.4</td>
<td>Initiates action, in consultation with patient/carer and/or prescriber to address identified issues</td>
</tr>
</tbody>
</table>
Consultation feedback

Respondents to the online survey were asked the extent to which they agreed with the statement that ‘A reduction in the level of detail and specificity in the current competency framework would improve the framework’s practical value without impacting negatively on the purpose for which it is used.’ Figure 13 reflects the responses.

Figure 13. Level of agreement that a reduction in the level of detail and specificity would improve the framework’s practical value without negatively impacting use

The extent to which there was agreement with this statement by respondents in the online survey varied across the different purposes for which the framework was used. This was corroborated in the consultation forums.

When used for regulation, respondents to the online survey agreed with a reduction in the level of detail, with the current level creating too many gaps about what is included and what is not. It was noted that, in general, the competency framework was used to discuss behaviours in conjunction with a set of other documents (e.g. codes, practice standards). While for some regulatory problems, there was sometimes not enough detail in the framework, however, this was often dependent on what other documents existed to support the particular regulatory problem.

When used for education leading to initial registration, divided views were expressed. One respondent in the online survey who was neutral in their view expressed that there needed to be a ‘balance between the level of detail and restrictions put due to that level of detail’.
Concern was expressed that if detail was reduced too far, then the framework becomes so generic that it may be worthless. The value of the evidence examples in designing assessment activities was also noted.

When used for ongoing professional development of pharmacists, there were also divided views. It was expressed that a reduced level of detail would allow for more innovation, and flexibility to progress different scopes of practice. The interview with the key opinion leader reinforced the need for pharmacists to be innovative in creating new roles to address identified public health needs; the competency framework should support this. However, without the detail, the relevance and understanding of the competencies may become unclear. A reduction in detail could lead to ‘unplanned ignorance or non-deliberate underperformance’.

Discussion in the consultation forums substantiated the divergent views. It was expressed that the detail is needed, e.g. in CPD accreditation to determine relevance of content, also for consistency in assessments of performance. However, to get usage by individual practitioners, a usable tool or summary document is needed. The example of the ClinCAT, a practical tool developed by SHPA, was discussed. With the ClinCAT, the detail is not used all the time, but the detail is available to assist when feedback needs to be provided.

In general it was expressed that a balance in the level of detail needs to be achieved. Further discussion in the consultation forums elicited that the overall structure of the framework is what needs to be considered when determining the level of detail:

- There was good support for a ‘core’ document. It was expressed that this may allow some of the detail to sit outside the framework itself and could support the contextualisation/translation of the document for different uses/purposes. It was expressed that finding the balance may be difficult, and so the whole of profession needs to take responsibility for the framework. Different groups of ‘users’ of the framework need to agree about what should be included in the core document and what should sit in supporting documents, and who needs to be involved in the development of the different supporting documents, to ensure a consistent whole-of-profession approach was achieved.

- There was good support for describing competencies in terms of behaviours, without breaking down (‘atomising’) each competency into tasks or activities. It was expressed that this could reduce the number of levels in the framework by combining the Elements and Performance Criteria into Observable Behaviours. The behaviours would need to be clearly expressed so that an objective assessment of performance can be made.

It was discussed that with increased maturity of the profession, there can be a reduced need for detail. It was also expressed that varying levels of detail may be needed for different domains (e.g. interns have expressed needing more support in relation to communication and ethics).

**Recommendation 2. Describe competencies in terms of observable behaviours.**

- Describing competencies in terms of observable behaviours will support an objective assessment of performance while valuing the inherent integration of tasks and complex conceptual, analytical and behavioural functions that underpin professional service delivery. It should improve the practical value of the framework by reducing bulkiness and fragmentation.

- Retain the level of detail necessary to support understanding of relevance, without being prescriptive and restricting flexibility and innovation.

- With reference to the current competency framework, this can be achieved by reducing the number of levels in the framework, consolidating Elements and Performance Criteria into Observable Behaviours.

Also refer to Recommendation 1.
2.4 Including markers of poor behaviour

Background research

In competency frameworks where observable behaviours are included, it is markers of good behaviour that are most commonly described (e.g. frameworks for pharmacists in Ireland\(^3^9\) and New Zealand\(^4^0\)). However, there are also examples whereby markers of poor behaviour have been developed.

For example, behavioural markers have been developed for the surgical profession in Australia and New Zealand to provide examples of both good and poor behaviour (see Figure 14).\(^3^4\) For each competency in the framework, a Pattern of Behaviour is identified. For each Pattern of Behaviour, markers of good behaviour are identified to provide guidance to surgeons whereby they may be seen as a role model for trainees or other surgeons. In contrast, markers of poor behaviour are identified as suggestive of underperformance and provide a basis for support and remediation of underperforming surgeons before patient safety or standards of care are compromised. This approach is promoted to support assessment of performance, including self-assessment, peer assessment, multi-source feedback and trainee assessment by supervisors.

Figure 14. Extract from Surgical Competence and Performance for the Competency ‘Professionalism’ and the Pattern of Behaviour ‘Having awareness and insight’\(^3^4\)

### Professionalism

Demonstrating commitment to patients, the community and the profession through the ethical practice of surgery

### Having awareness and insight

Reflecting upon one’s surgical practice and having insight into its implications for patients, colleagues, trainees and the community

<table>
<thead>
<tr>
<th><strong>Examples of poor behaviours</strong></th>
<th><strong>Examples of good behaviours</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Is difficult to contact post-operatively and admonishes staff for continued attempts to make contact</td>
<td>Adopts a courteous approach to other staff and patients</td>
</tr>
<tr>
<td>Blames registrars or others for poor outcomes</td>
<td>Responds positively to questioning, suggestion and objective criticism</td>
</tr>
<tr>
<td>Books inappropriately long lists or is misleading with theatre staff/anaesthetists regarding the length of operations</td>
<td>Admits to errors</td>
</tr>
<tr>
<td>Berates or humiliates subordinates</td>
<td>Acknowledges poor outcomes and takes opportunities to reflect and improve</td>
</tr>
</tbody>
</table>

Assessment  
* Poor  
* Marginal  
* Good  
* Excellent  
* Unable to Rate
Consultation feedback

Respondents to the online survey were asked the extent to which they agreed with the statement that ‘The development of markers of poor behaviour would be useful in the assessment of performance, providing a basis for support and remediation.’ Figure 15 reflects the responses.

Figure 15. Level of agreement that the development of markers of poor behaviour would be useful in the assessment of performance, providing a basis for support and remediation.

Pharmacy organisations. Feedback from pharmacy organisations in the online survey showed there was strong support for the development of markers of poor behaviour for the assessment of performance.

When used for regulation, respondents in the online survey expressed that markers of poor behaviour would be a useful tool for self-regulation, improving awareness of what constitutes poor behaviour in certain instances. They would particularly assist when behaviour is not easily determined to be either acceptable or unacceptable.

When used for education leading to initial registration, respondents in the online survey expressed that they would assist poor behaviour being recognised and addressed, rather than being potentially perpetuated. They would also provide insight for students on what constitutes poor behaviour.

When used for ongoing professional development and in the workplace, respondents in the online survey expressed that this type of performance feedback could be used by an individual to plan, focus and improve in their specific areas of need. It would also remove any ambiguities.
When discussed at the consultation forums, there was substantially less support for developing markers of poor behaviour. The term ‘poor behaviour’ was felt to be inappropriate and a more professional language should be used. The challenge of identifying the line between poor and good behaviour was raised, with concern expressed that a list may be misinterpreted as representing the only poor behaviours.

Concern was expressed in the consultation forums about how lists of poor behaviours might be misused. Views were expressed that poor behaviours needed to be defined for a particular environment, e.g. by an employer or regulator. This contextualisation or translational step was considered important. It was also expressed that identifying poor behaviour should occur in the context of a performance development cycle, to assist in the remediation of practitioners, not to reprimand or terminate employment.

When discussed in the context of people making complaints about an individual practitioner, it was expressed that those reporting poor behaviour would be reporting on a specific activity, rather than a listed behaviour.

In general it was expressed that there may be benefit in identifying markers of poor behaviour at the level of an individual or specific environment and for a specific purpose. However, for the purposes of the competency framework, there appeared to be general agreement that observable behaviours of ‘good’ performance could be sufficiently descriptive to assist in providing feedback and help insight, without defining poor behaviours.

**Individual practitioners.** Feedback from individual practitioners in the online survey also showed there was strong support for the development of markers of poor behaviour for the assessment of performance, although they acknowledged the difficulty in developing and implementing such a ‘list’. Those not supporting this feature raised issues about what examples would be used and whether such examples would then (inappropriately) create a baseline level for performance. It was expressed that this level of detail may better exist in a performance management tool.

**Non-pharmacy organisations.** Feedback from non-pharmacy organisations in the online survey were less supportive of the development of markers of poor behaviour for the assessment of performance. Feedback expressed included the potential for markers of poor performance to have a negative impact, in contrast to positive statements which can be more empowering. It was expressed that competency standards for professionals should provide a positive means for self-improvement and allow assessment of competence, and not be seen as ‘bringing in the stick’. Respondents felt that other systems should inform poor performance (e.g. complaints, incidents), and that poor behaviour should be managed at the level of the individual as part of performance management.

**Recommendation 3.** Retain only markers of good behaviour in the competency framework, and not markers of poor.

- Ensure behaviours are sufficiently descriptive to assist in providing feedback and help insight into behaviour, without defining poor behaviours
- Consider the development and use of markers of poor behaviours in performance management tools.
2.5 Grouping competencies

Background research

Competency framework models typically group competencies into ‘domains’ relating to an area of responsibility or professional endeavour (e.g. Communication or Deliver primary and preventive health care). This is the model used in the current competency framework for pharmacists in Australia.

More recently, there has been a trend towards grouping competencies according to ‘roles’ (e.g. Communicator or Health Advocate). This is the model used in the CanMEDS Physician Competency Framework (and the increasing trend may be associated with the uptake of this model in over 16 countries, including Denmark, the Netherlands, New Zealand and Australia). Despite this trend, it has been argued that roles and competencies are not synonymous. Roles are a social construct, and competencies are a behavioural manifestation. Further, neither should be confused with professional identity which forms as an adaptive, developmental process at the level of the individual (through their psychological development) and at the collective level (through their socialisation into appropriate roles and participation in the community and work).

Both the ‘domains’ and ‘roles’ models are now commonly used, and neither is unquestioningly accepted as the ‘right’ or ‘best’ approach. With either model, professional practice requires integration of competencies across the domains or roles, and both models have been criticised for such things as limiting attention to relational and situational factors, limiting the ability to capture the complex nature of expertise, fragmenting elements of professional competence and imposing limitations on understandings of professional work.

Where role-based competency models are used, the specific names chosen to describe roles are considered significant. The ‘roles’ should not be considered inherently ‘natural’ or ‘self-evident’, but decided in specific historical, cultural, social and national contexts. The language and imagery to describe, divide and reintegrate roles has been reported to affect how the roles are understood, valued and enacted.

The CanMEDS Framework was developed for physicians in Canada and was released in 2005. It ‘is based on the seven roles that all physicians need to have to be better doctors: Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional’. For each role, there are key competencies which are further described by enabling competencies.

The Eight-Star Pharmacist provides a comparable grouping of roles for pharmacists as CanMEDS does for physicians, with the concept first introduced in 2000 by the World Health Organization and adopted by the International Pharmacy Federation as the Seven Star Pharmacist.

The eight roles now reflected are Caregiver, Decision-maker, Communicator, Manager, Life-long learner, Teacher, Leader, and Researcher.

Consultation feedback

Respondents to the online survey were asked the extent to which they agreed with the statement that ‘The way in which competencies are grouped affects my use of the competency framework and the way a pharmacist’s role is perceived.’ Figure 16 reflects the responses.
Figure 16. Level of agreement that the way in which competencies are grouped affects my use of the competency framework and the way a pharmacist’s role is perceived

<table>
<thead>
<tr>
<th>Domain</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workplace</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regulation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-pharma</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pharmacy and non-pharmacy organisations. Feedback from pharmacy organisations in the online surveys showed varying views about the way competencies should be grouped in the competency framework, with many respondents feeling that it had no impact either way on the way the framework is used or a pharmacist’s role perceived. Of those respondents who believed the grouping did affect use and the way a pharmacist’s role is perceived, there were mixed preferences for grouping according to domains (areas of professional responsibility) or roles.

Individual practitioners. Feedback from individual practitioners in the online survey showed a particularly neutral response, with a number of respondents expressing that this would not make a difference practically.

The neutral views and mixed preferences expressed in the online surveys were consistent with those expressed in the consultation forums. However, on further discussion, views were expressed, and generally supported, that:

- The Domains in the current competency framework reflect the traditional roles of pharmacists, and that renaming and regrouping them could achieve a better reflection of emerging and future roles.
The groupings, whether they are domains or roles, be described in a consumer-focused way. The domains should be phrased to reflect the impact on or end result for the consumer. The terms used should also provide consumers and health professions clarity about the pharmacist’s role. While it was suggested that the ‘8-star pharmacist’ may provide guidance when reviewing the groupings, the terminology was not always supported as reflecting the pharmacists’ actual role e.g. the term ‘caregiver’.

The development of competencies be supplemented with consideration of professional identity formation. Care was needed not to limit pharmacists’ roles or negatively affect their perception of themselves and each other. However, it was expressed that the formation of professional identity required consideration much further beyond just the competency framework.

In the consultation forums, an evolutionary change to groupings was proposed, with the first focus being the scope of roles covered in the current Domains 4, 5 and 6 to better reflect contemporary practice and emerging and future roles.

**Recommendation 4.** Retain grouping competencies according to domains (areas of professional responsibility).
2.6 Reflecting variations in scopes of practice

Background research

In Australia, of the professions regulated under the National Law, extended scopes of practice may be recognised as an ‘endorsement’ of registration, recognising that a person has additional qualifications and expertise in an approved area of practice and/or for scheduled medicines. Table 4 lists the current endorsements available and how competency frameworks have been used to reflect the competencies of the extended scope of practice.

Table 4: Current endorsements recognised under the National Law

<table>
<thead>
<tr>
<th>Endorsements available under the National Law</th>
<th>Profession</th>
<th>Reflection of additional expertise within the respective competency framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endorsement for scheduled medicines</td>
<td>Nursing: Registered Nurse</td>
<td>No reference to a competency framework; specific programs specified for individuals to achieve endorsement are approved by the Nursing and Midwifery Board. Unique framework within registration guidelines defining the four components of prescribing, and which is not aligned with the competency framework for registered nurses.</td>
</tr>
<tr>
<td></td>
<td>Eligible Midwife</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Optometry</td>
<td>Single competency framework with hierarchy of units, elements, performance criteria, and some suggested indicators. Indicators are identified as either ‘universal’ or ‘therapeutic level’. Endorsement requires completion of accredited program that meets therapeutic level competencies.</td>
</tr>
<tr>
<td></td>
<td>Podiatry</td>
<td>Single competency framework with hierarchy of competency standards, elements, performance criteria, and examples of evidence. Supplementary elements relevant to medicines prescribing are identified (and align with NPS framework). Endorsement requires completion of accredited program, where accreditation standards link to these competency standards.</td>
</tr>
<tr>
<td>Endorsement as a nurse practitioner</td>
<td>Nurse Practitioner</td>
<td>Unique competency framework for Nurse Practitioners that is not aligned with the competency framework for registered nurses</td>
</tr>
<tr>
<td>Endorsement for acupuncture</td>
<td>Any health profession (other than those registered by the Chinese Medicine Board of Australia)</td>
<td>No reference to a competency framework; specific programs approved by Board. Note: the practice of acupuncture is not a protected practice; endorsement only required to use the title ‘acupuncturist’ or funding requirements (e.g. Medicare or health insurance).</td>
</tr>
</tbody>
</table>
Internationally, there are also examples of competency frameworks that reflect advanced, extended or different scopes of practice. However, where such frameworks exist, they tend to be separate to the framework for entry to practice and without alignment.

In the United Kingdom, the General Level Framework has been developed to support post-registration development for pharmacists delivering general pharmacy services working in hospital, community pharmacy and primary care. Another framework has been developed to reflect the competencies required for specific advanced services (e.g. for the assessment of pharmacists providing the medicines use review (MUR) and prescription intervention service), which does not align with the General Level Framework. The Advanced and Consultant Level Framework (ACLF) for pharmacists in the UK has also been developed to support post-registration development for all pharmacists progressing to advanced levels of practice. It is promoted as a generic framework that can be used across the profession for specialist and advanced practice.

In Canada, a competency framework for pharmacists at entry to practice exists. In addition to this, Model Standards of Practice (MSOP) exist primarily for pharmacy regulatory authorities. Like the competency framework for entry to practice, these are also competency-based standards. However, they apply to all pharmacists (not just those at entry to practice), and have the goal of specifying the standards against which pharmacist’s performance can be judged.

In developing the current version of the MSOP, the need to be able to reflect shifting and overlapping scopes of practice and emphasise accountability of professionals throughout their careers was explicitly noted. As such, for each ‘General Standard’ (which are grouped within four domains: Expertise in medications and medication use; Collaboration; Safety and Quality; and Professionalism and Ethics), the MSOP that are required of all pharmacists regardless of the role they are fulfilling are identified, as well as those MSOP that are specifically associated with the five pharmacist roles identified in the entry-level competency framework (patient care, drug information, drug distribution, management, and education) (see Table 5). The regulators recognise that not all pharmacists perform each of the roles. However, it is their intention that when a pharmacist does perform a specific role, they meet all the MSOP associated with this role.
### Table 5: Model Standards of Practice for Canadian Pharmacists – example of format

<table>
<thead>
<tr>
<th>General Standard</th>
<th>Model Standards of Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expertise in medications and medication-use</strong></td>
<td></td>
</tr>
</tbody>
</table>
| 1. Pharmacists maintain their competence. | MSOP required of pharmacists regardless of the role they are fulfilling:  
• fulfil the provincially mandated requirements for maintenance of competence (e.g. CE, practice assessment, learning portfolio)  
• adhere to current laws, regulations and policies applicable to pharmacy practice  
MSOP required of pharmacists when providing patient care:  
• maintain all certifications/credentials required for their practice including emerging scope of practice activities that are authorized in specific provinces  
MSOP required of pharmacists when providing drug information:  
• …  
MSOP required of pharmacists when responsible for drug distribution:  
• …  
MSOP required of pharmacists when managing a pharmacy:  
• …  
MSOP required of pharmacists when educating pharmacy students/interns:  
• … |
| 2. Pharmacists apply their medication and medication-use expertise while performing their daily activities. | MSOP required of pharmacists regardless of the role they are fulfilling:  
• …  
MSOP required of pharmacists when providing patient care:  
• …  
MSOP required of pharmacists when providing drug information:  
• …  
MSOP required of pharmacists when responsible for drug distribution:  
• …  
MSOP required of pharmacists when managing a pharmacy:  
• …  
MSOP required of pharmacists when educating pharmacy students/interns:  
• … |
Consultation feedback

Respondents to the online survey were asked the extent to which they agreed with the statement that ‘A competency framework that provides a clear mechanism for demonstrating competence in, or capability for, extended scopes of practice should be pursued.’ Figure 17 reflects the responses.

Figure 17. Level of agreement that a competency framework that provides a clear mechanism for demonstrating competence in, or capability for, extended scopes of practice should be pursued

Of all the features of the competency framework model proposed to individual practitioners, a clear mechanism for demonstrating competence in, or capability for, extended scopes of practice was the most strongly supported feature by individual practitioners in the online survey. The support for this option is probably higher than the results above suggest, as a number of respondents who selected ‘Disagree’ or ‘Strongly Disagree’ commented that they felt they already had a clear mechanism for doing this.

Feedback from pharmacy organisations in the online surveys also showed strong support for having a competency framework that provided a clear mechanism for demonstrating competence in, or capability for, extended scopes of practice.

In relation to the use of the competency framework for regulation and ongoing professional development, it was expressed that levels of performance should be considered for extended scopes of practice, but that this should be within a ‘Performance Framework’ for qualified pharmacists as opposed to core competencies required to become a pharmacist.
In relation to the use of the competency framework for education leading to initial registration, agreement was reinforced by comments that the link between the competency standards and reality in practice is vital to ensuring the standards are relevant and understood. However care would be required to establish context to avoid confusion for students.

In the consultation forums, concern was expressed that a competency framework that was too prescriptive in defining extended scopes of practice would lead to a loss of flexibility for the profession in taking up new opportunities. There was general agreement that the framework needs to be kept open enough to support, not limit, opportunities for new services. Such contextualisation could then occur within evidence guides. The Competence Standards for the Pharmacy Profession in New Zealand were referenced, noting how they appear to have thought about what pharmacists do (e.g. administration), but not been specific about the service (e.g. vaccination). Similarly, the review of the competency framework for pharmacists in Australia needs to allow for such things as point-of-care testing, but focusing on the competencies required (e.g. patient contact).

Feedback in the consultation forums included a need to consider the competency framework ‘matching’ with privileging and credentialing processes. Competencies can then be included in the profession’s scope of practice, even if individual pharmacists are not yet authorised to perform the services. This will allow for rapidly changing roles to be captured.

Refer to Recommendation 1.
2.6 Reflecting the performance continuum

Background research

There are few examples of single competency standard frameworks that express the performance continuum from novice to expert (or equivalent) as a primary feature.

The current (2005) CanMEDS Framework describes the competencies expected of trainees at the end of their training (i.e. at the point when they are ‘ready’ to enter practice). However, an updated CanMEDS Framework is planned for release in 2015, with the most significant change being the introduction of milestones to ‘describe the development of physician abilities across the continuum of their career starting at entry to residency, following them throughout practice, and finally into the transition out of professional practice’ (see Figure 18).

Figure 18. The CanMEDS 2015 Competence Continuum
Both the competencies and milestones describe the abilities to be demonstrated in practice, as distinct from the information or content related to aspects of a ‘Role’. There are milestones for each enabling competency, and between zero and four abilities listed for each milestone (see Figure 19 for an example). As each milestone builds on the previous one, where zero abilities are listed for one milestone, this reflects that there are no additional expectations for that competency as compared to the previous milestone. The milestones are included as a companion document, rather than integrated into the main document. In response to consultation feedback in the development of CanMEDS 2015, the recommendations to use ‘plainer language’ throughout and have fewer milestones have been addressed.

Figure 19. The CanMEDS 2015 Competence Continuum – extract for one enabling competency

Another example of a competency framework that expresses the performance continuum in a single framework is that developed for social workers in England (see Figure 20). A number of resources support the framework to facilitate understanding, assessment and certification at the various levels, as well as progression between levels.

Figure 20. Professional capabilities framework for social workers
Consultation feedback

Pharmacy organisations responding to the online survey were asked the extent to which they agreed with the statement that ‘The milestones in a performance continuum for pharmacist competencies (e.g. from Incompetent to Master) should exist within one competency framework.’ Figure 21 reflects the responses.

Feedback from individual practitioners in the online survey was that there was good support for the milestones in a performance continuum existing within one competency framework. It was seen as logical as development and learning is a continuum. It was also expressed that such a model would make the distinction between beginner and advanced practitioner. Those who disagreed with the statement were primarily concerned with the terminology used for the different performance levels and implementation.

Feedback from pharmacy organisations in the online survey also showed good support for the milestones in a performance continuum existing within one competency framework. Those who agreed with the statement expressed that this may provide a good way to assess development over time, as well as provide a ‘snap shot’ at a particular moment in time, informing an individual that potential further improvement is possible.

In relation to the use of the competency framework for ongoing professional development, it was expressed that having only competent and ‘not yet competent’ fails to recognise the actual level attained (e.g. someone may be a ‘master’ at something but is graded the same as someone who is only just acceptably competent).
It was also expressed that the model would allow feedback to be provided in a positive manner, which the individual may use to challenge themselves to reach the next level.

Those who were neutral or disagreed with the statement expressed that one competency framework, which includes the continuum of performance for pharmacists through their career, has the potential of being large and unwieldy. A preference for a document that separated competency and performance levels was expressed.

Similar views were expressed in the consultation forums. It was expressed that it was useful to display the journey, and that the ‘building blocks’ already exist within the Advanced Pharmacy Practice Framework.

However, there was concern that the level of detail presents a risk. It was expressed that it is desired that individual pharmacists use the framework; however including the milestones would be too much in one document. It was also expressed that the framework should not be so detailed that it becomes inflexible, but with so many different scopes of practice, the statements would become too generic and there is risk that professional identity would be lost.

Misinterpretation of the milestones was also expressed to be a risk, particularly in relation to the timeframe in which it was expected that milestones be achieved.

There appeared to be general agreement in the consultation forums that, while it is a good concept, there was risk in trying to do too much with one document. A core competency document was required, with performance levels (aligning) in a separate document. The need to establish a set of tools for individuals, managers and others was expressed to support contextualisation.

Refer to Recommendation 1.
2.7 Consistent frameworks across different professions

Background research

Patient centred care and collaborative practice is adversely impacted when competency frameworks are used to limit activities and roles to certain professions.\(^2\) Increased inter-sectoral alignment between frameworks has been recommended so that whole of health workforce developments maximise the potential for shared learning pathways, recognition of prior learning and articulation agreements.\(^63\)

Consultation feedback

Respondents to the online survey were asked ‘Would consistency in competency frameworks across different professions facilitate scope of practice changes, without impacting negatively on the purpose for which they are used for individual professions?’ Figure 22 reflects the strength of responses, according to the different groups surveyed.

Figure 22. Support for consistency in competency frameworks across different professions
**Pharmacy organisations.** Pharmacy organisations responding to the online survey showed greatest support for consistency across competency frameworks in the context of them being used for regulation. It was expressed that all health professionals share responsibilities and professional activities to some extent that are reflected in their competency frameworks. A consistent approach would aid interprofessional understanding, trust and collaboration.

In relation to other uses of the framework, pharmacy organisations supportive of consistency across frameworks expressed that conceptually, core behaviours are cross-profession. It was expressed that a common structure and consistent definitions would be helpful, but the performance criteria would need to be profession/role-specific. Examples were provided of how common frameworks have already been achieved for activities that fall across a number of healthcare professionals, and it was suggested these be consulted for specific aspects during the review. These are discussed further in Part 3 (including a listing in Table 8).

From the perspective of meeting the healthcare needs of the public, respondents identified circumstances where common/core areas of competence between health professionals would be beneficial. In preparing a submission to the Australian Diabetes Educators Association to change the eligibility requirements for pharmacists to become Credentialled Diabetes Educators (CDE), extensive mapping of the CDE competency criteria and pharmacy competencies was required, including with consideration of students, interns, overseas trained pharmacists, entry-level pharmacists and registered pharmacists. Having a competency framework across different professions would assist in recognising core skills and competencies and facilitate scope of practice changes.

Concern was expressed that consistency between frameworks could result in role confusion, and that with professions being quite different, discipline specific frameworks are more relevant.

**Individual practitioners.** Individual practitioners responding to the online survey who were supportive of consistency across frameworks expressed that this approach could support an understanding of roles, collaboration and communication between professions. Competencies for which consistency would be appropriate were identified as communication, patient-centred care, professional practice, ethics and prescribing.

Those who did not support consistency expressed that it would be difficult to get agreement across professions, that too much commonality may create role confusion (for professionals and the public), and the competency framework may become too generic to be useful.

**Non-pharmacy organisations.** Non-pharmacy organisations responding to the online survey had a divided response as to whether there was benefit in having consistency across competency frameworks.

Respondents supportive of consistency across frameworks expressed that it is a major and important issue that needs attention. One respondent expressed that each discipline has some unique contribution to make, but there remains a range of basic services that can be delivered by a registered health professional. Regardless of the discipline of the profession, the service should be carried out to the same standard. Another respondent expressed that primary healthcare is about coordination and integration – bringing together multidisciplinary teams to manage patient outcomes. Consistency of frameworks would facilitate seamless integration.
Respondents who were unsure or not supportive identified that there were domains where competency is common across all health professions (e.g. communication, ongoing education) and there may be benefit in alignment. ‘Facilitating scope of practice changes however is an entirely different consideration and has a history of significant challenges particularly if a particular health profession feels it is losing ground to another profession, i.e. nurse practitioners including those with prescribing rights, podiatric surgeons in conflict with orthopaedic surgeons. Healthcare turf is highly valued and guarded.’

Respondents to the online survey were asked ‘For which professions do you think competency frameworks could ideally be aligned?’ Responses are reflected in Figure 23.

**Figure 23. Health professions for which competency frameworks may align with pharmacists**

Discussion in the consultation forum identified similar views to those expressed in the online surveys. One participant expressed that they had had good experiences changing scopes of practice in a multidisciplinary team as a result of negotiation between members, however the challenge was how such changes could be supported outside the immediate team.

**Recommendation 5.** Initiate discussions with other healthcare professions with a medium to long-term goal of developing a common structure and consistent terminology for the competency frameworks of all healthcare professions.
2.8 Supporting implementation

Background research

Within the literature, it is the implementation of competency frameworks that has been reported to raise the most concerns. Used inappropriately, any benefits can be negated. Implementation is reported to be of greatest concern where competency frameworks are ‘atomised’ into a large number of behaviours or performance criteria, and require evidence of competence to be assembled at this level. Such bureaucracy can reduce the assessment of complex behaviours to a tick-box exercise.

Tools to facilitate implementation of the competency standards identified in the consultation paper were the Customised Entry-level Competency Tool for Pharmacists and entrustable professional activities. Another commonly referenced during consultation was the ClinCAT.

Customised entry-level competency tool

The entry-level competencies are to be met at entry to professional practice. However, they also serve as a source of guidance to the teaching and learning expected across both the pharmacy degree program and the intern training program. In this regard, the Customised Entry-level Competency Tool for Pharmacists was developed to assist with identifying the contributions of pharmacy programs and intern training programs to the learning and development of students and intern pharmacists, respectively.

Entrustable professional activities

The introduction of entrustable professional activities (EPA) has been proposed to address criticism that:

- Current concepts of competence ‘fail to account for the essential interplay between competencies and the contexts of practice’; and
- While workplace based assessments can be developed as valid assessments of specific competencies, they do not assess competence against an integrated set of competencies.

EPAs are defined as professional activities that should be entrusted only to those individuals who have adequate competence to carry them out.

As such, they must:

- Be essential professional work that can only be carried out by a qualified person;
- Require knowledge, skill and attitudes that are generally acquired through training;
- Lead to recognised output of professional work;
- Be independently executable within a specific timeframe;
- Be observable and measurable in process and outcome; and
- Reflect one or more competencies to be acquired.

The EPA concept is intended to be used in conjunction with competency frameworks. An example of a competency framework-EPA matrix is provided in Table 6. For a particular profession or training program, levels of entrustment are defined for the EPAs which formally acknowledge the level of supervision required (e.g. proactive, ongoing, full supervision required; reactive supervision required (i.e. supervision is readily available on request); may act independently; or may act as a supervisor and instructor).


Table 6. Example of a competency framework-EPA matrix

<table>
<thead>
<tr>
<th>Professional activities</th>
<th>CanMEDS roles</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical expert</td>
</tr>
<tr>
<td>Performing a venepuncture</td>
<td>●</td>
</tr>
<tr>
<td>Performing an appendectomy</td>
<td>●</td>
</tr>
<tr>
<td>Signover at morning report after a night shift</td>
<td>●</td>
</tr>
<tr>
<td>Developing and implementing a patient management plan</td>
<td>●</td>
</tr>
<tr>
<td>Chairing a multidisciplinary meeting</td>
<td>●</td>
</tr>
<tr>
<td>Requesting an organ donation</td>
<td>○</td>
</tr>
</tbody>
</table>

● = competency is absolutely needed. ○ = competency is needed, but to a lesser extent.

EPAs have been introduced as part of the education requirements for a number of medical practitioner groups (general and specialist) in various countries, with the benefit appearing to be largely in supporting meaningful workplace-based assessment of competencies derived from a competency framework.

It is still unresolved how best to assess entrustment levels for any given EPA, however the need to ground assessments of competence in authentic and complex tasks is a need supported across education more broadly.

Assigning a level of entrustment is likely to at least depend on:

- The competence of the learner
- The approach and skills of the supervisor
- The nature of the EPA
- Local circumstances or context (e.g. time of day, emergency situation).

An example of how competencies, as they relate to an EPA, can be used to support students and supervisors in workplace-based assessment is provided in Table 7.
### Table 7: Example of competencies for the EPA ‘Initiating medication’ to support workplace based assessment of trainee psychiatrists

<table>
<thead>
<tr>
<th>Role</th>
<th>Indicative Questions</th>
</tr>
</thead>
</table>
| Medical expert  | The trainee demonstrates the ability to make an accurate diagnosis, has conducted the appropriate assessments, can describe the evidence for the use of the medication, its dosage, interactions and side effects                                                                                     | Has an appropriate assessment been completed?  
Is the use of this medication evidence-based?  
Are there any contraindications to the use of this medication (significant interactions etc.)?  
Is the dosing regime correct?  
Have appropriate investigations been performed?  
What plan is there to assess outcome? |
| Communicator    | The trainee shows the ability to explain to the patient the benefits and risks of the medication and how it should be taken and addresses the patient’s questions                                                                                                                                                                                                                     | Have the reasons for the use of this medication been explained so that the patient is able to understand?  
Have the benefits of the medication been explained?  
Have the risks (major side-effects) of the medication been explained?  
Has the patient been explained about what to do should side effects emerge?  
Has the dosing regime been explained so that the patient understands?  
Has the need for further investigations been explained?  
Have the patient’s questions been responded to appropriately? |
| Collaborator    | The trainee ensures that members of the MDT (and GP) are aware of how the medication fits in with the management plan                                                                                                                                                                                                                                                                                                                                                         | Has information about the medication been communicated with the MDT?  
Has information about the medication been communicated with significant others?  
Has the GP been informed? |
| Professional    | The trainee has obtained informed consent                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Has informed consent been obtained?  
Are there any conflicts of interest? |
| Scholar         | The trainee is able to apply the evidence from clinical practice guidelines                                                                                                                                                                                                                                                                                                                                                                                                                                      | What is the evidence base for the medication?  
What process will be used to evaluate outcome?  
Can the trainee explain the mechanism of action? |
| Health advocate  | The trainee ensures that the patient is able to access the medication                                                                                                                                                                                                                                                                                                                                                                                                                                          | Has there been a check on whether the patient can access the medication?  
Has there been a check on whether the patient can afford the medication?  
Has the appropriate authority form been used? |
| Manager         | Clear and accurate documentation is completed                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Is the documentation in the case note clear and accurate?  
Has the medication form (prescription) been completed correctly?  
Has the use of health resources been considered? |
Consultation feedback

It was reported during the consultation forums that, when developing the current competency standards framework, implementation had been identified as an important factor in ensuring its value. There had been significant progress in some areas. However, the value to be gained from having all ‘users’ engaged in this process of reviewing the framework with a shared understanding of how the competency framework will be used for the different purposes, was recognised.

Feedback was provided about two specific approaches to implementation: the Customised Entry-level Competency tool and entrustable professional activities.

Customised entry-level competency tool

Pharmacy organisations responding to the online survey in relation to the use of the competency framework for education leading to initial registration were asked how effective they found the Customised Entry-level Competency tool. The reported effectiveness is displayed in Figure 24. Those respondents reporting that it was ineffective explained this as due to it being ‘a large a cumbersome document’. A provider of intern training expressed that they had tried to map the training program to the tool, but it was ‘too messy’, noting that intern training program providers are required to assess to the level of Element, but this document went into too much detail and levels beyond this.

![Figure 24. Reported effectiveness of the Customised Entry-level Competency tool for education leading to initial registration](image-url)
Entrustable professional activities

Pharmacy organisations responding to the online survey were asked the extent to which they agreed with the statement that ‘Interpretation and implementation of the competency framework would be assisted by the development of entrustable professional activities (EPAs).’ Figure 25 reflects the responses.

Figure 25. Level of agreement that interpretation and implementation of the competency framework would be assisted by the development of entrustable professional activities

Feedback in the online survey showed good support for the development of EPAs for many of the contexts in which competency frameworks are used.

Pharmacy organisations who supported the development of EPAs expressed that:

- In relation to the use of the competency framework in regulation, EPAs would assist with the articulation of the competency framework with the advanced practice framework.
- In relation to the use of the competency framework for education leading to initial registration, EPAs would clarify for interns and preceptors what activities require supervision and the level of supervision required.
- In relation to the use of the competency framework for ongoing professional development, EPAs would provide clarity as to the roles, competencies and responsibilities required to carry out specific professional tasks. It would also indicate gaps and opportunities for the development of individual practitioners.
- More generally, EPAs will assist in workplace based assessment.
However, concern was expressed by pharmacy organisations about it becoming an extensive and detailed document.

During the consultation forums, it was proposed that the statement should be reversed – that the competency framework would assist the development of EPAs. It was discussed that, in essence, this approach was already being pursued, e.g. in relation to regulation, for the purposes of credentialing/privileging and in constructing indicative questions against competencies for performance assessments. Further, the notion of entrustment was also used in relation to activities, but at the level of the person (e.g. student vs intern vs registered pharmacist) rather than the specific activity. It was expressed that EPAs could be a useful tool, but should not be prescribed.

Other factors affecting implementation

A key opinion leader interviewed during the consultation reported a number of barriers to successful implementation of the competency framework and its ability to contribute to building a competent pharmacist workforce. The barriers identified included the restrictions on the types and number of sites for intern placements, which are both influenced by the funding model of employer-paid and the Pharmacy Board of Australia registration standard. There are no doubt other factors which may affect whether the framework can achieve the desired outcomes. While these were outside the scope of this research and consultation process, they will also require discussion and consideration by PPDC.

Recommendation 6. Achieve effective implementation by developing a whole-of-profession communication and implementation plan.

Development of the plan should:

- Involve representatives of all users of the document, across all purposes for which the framework is to be used
- Identify mechanisms for developing consistent guidance material and tools on the development and use of the framework.

The plan should prioritise:

- A review of the *Customised Entry-level Competency Tool for Pharmacists*, given the reported value of the competency framework in the development of education leading to initial registration
- Engaging individual practitioners in using the Competence Framework and Performance Framework
- Mechanisms for demonstrating competence in, or capability for, extended scopes of practice.
3. Competency standards to reflect contemporary practice and emerging and future roles

3.1 Background research

There is evidence that the current organisation of health professionals and their associated scopes of practice are not meeting the needs of the Australian public. The current organisation of roles is also reported to have no existing evidence base, and has not adapted to changes in the health needs of an ageing population and the clinical and technological responses that have altered the nature and location of care.68

The health workforce reform agenda

With the bill to abolish Health Workforce Australia (HWA) passed in September 2014, the strategic plan for the health workforce in Australia is currently unclear. It is reported that the HWA Health Workforce 2025 study identified that productivity gains can be made through changing models of care, adjustments to practitioners’ skills mix, health professionals working to their full or expanded scope of practice, and technological changes, such as utilising e-health or telehealth innovations. Other changes to health policy have shifted focus away from acute care and towards primary care and the prevention of chronic disease, and the treatment of chronic and aged related diseases in the community.69

The National Registration and Accreditation Scheme (NRAS), established under the National Law, has a very strong focus on embedding and promoting responsiveness, flexibility, innovation, sustainability and access to services in accordance with public interest as key objectives surrounding the regulation of health professions. Every agency within NRAS is expected to contribute to these objectives and behave in a manner consistent with the objectives and guiding principles. However, preliminary feedback in the review of NRAS identified that better articulation of the workforce reform agenda and priorities would assist the agencies better fulfil responsibilities in this area.70

Competency frameworks to facilitate workforce reforms

Adapting the workforce faces challenges created by existing legislation and regulation, funding models for professional services and entrenched professional cultures.68 Public interest is central to health policy reforms. If competency frameworks are to be used to facilitate changes in scopes of practice, it is important to ensure public and patient interest is central in their development. Further, the development process should be such that criticisms of competency frameworks reported in the literature, such as them serving the practitioner’s economic interest; reinforcing professional norms, behaviours and attitudes; perpetuating existing domains of professional legitimacy; or protecting the profession from declining appreciation of its importance, are unfounded.41

From the 2013 review of Australian Government Health Workforce programs,69 areas of public need being addressed by these programs, and that have a ‘competence’ requirement across all health professions, are listed in Table 8. Competency frameworks and other resources that have been developed in Australia in response to these needs, and that should be consulted in the review of the competency framework for pharmacists, are also listed. Ethics and professional autonomy have also been reported to be issues of vital importance to pharmacists, and all health professions, in ensuring top priority to serving the best interests of patients and society at large.71
Table 8: Areas of public need and competency frameworks and other resources that have been developed in response to area of public need

<table>
<thead>
<tr>
<th>Area of public need</th>
<th>Australian competency frameworks and other resources developed in response to area of public need</th>
</tr>
</thead>
</table>
| Aboriginal and Torres Strait Islander health | - Aboriginal and Torres Strait Islander Health Curriculum Framework (draft in development). Australian Government; 2014.  
| Allied health leadership | - Health LEADS Australia: the Australian health leadership framework. HWA; 2013 |
| Clinical supervision and delegation | - National clinical supervision competency resource. HWA; 2013.  
- National clinical supervision support framework. HWA; 2011.  
- Supervision and delegation framework for allied health assistants; State Government of Victoria; 2012. |
| Interprofessional collaboration | - Interprofessional capability framework. Faculty of Health Sciences, Curtin University; 2011.  
| Mental health care | - Mental health care project: a framework for pharmacists as partners in mental health care. PSA; 2013. |
| Technological changes, e.g. eHealth or telehealth innovations | [None identified in Australia, but international e-health competency frameworks for health professionals exist as a reference point, e.g. Canada⁷⁷, Scotland⁷⁸] |

More often than not, the centrality of public and patient need in the development of competency frameworks for professions is assumed, but not explicitly stated, in frameworks. Where development processes are published, public consultation is often cited. However, the extent of the input or how such input has been incorporated is often not reported.

When developing the Model Standards of Practice (MSOP) for Canadian Pharmacists,⁵⁹ the rapidly changing scope of pharmacy practice in Canada was recognised. As such, pharmacist activities that related to emerging scope of practice activities (e.g. extending prescriptions, ordering laboratory tests, administration of
medications by injection) were still included even though authorisation varied between provinces and was changing substantially as legislation was being revised to meet public need.

**Facilitating emerging and future roles for pharmacists**

The literature identifies six different ways of ‘adding new tasks’ to health professional roles (see Figure 26).

**Figure 26. Ways of ‘adding new tasks’ to health professional roles**

Extending existing roles can be accommodated within the existing scope of practice by extending the *breadth* of the role (as experienced recently with pharmacist vaccination) or extending the *depth* of the role. Alternatively, the extension of existing roles can be accommodated with a change in scope of practice of the role, and this may be achieved by diversification (broadening professional practice to include new areas of practice) or specialisation with increased expertise.  

Achieving changes to scope of practice is reported to be achieved through three mechanisms: *interprofessional collaboration* (i.e. negotiated agreement among different health practitioners), *delegation* (i.e. where responsibility is assigned to another practitioner, but accountability remains with the delegator) or *substitution* (i.e. where both responsibility and accountability are transferred). It has been suggested that the development of a whole-of-workforce competency framework for the Australian health workforce would facilitate such changes, increasing workforce flexibility to meet new and emerging demands on the health system.

There is a relatively poor evidence base for the evaluation of scope of practice changes. Some ‘successful’ changes to scopes and roles are reported. However, success is often related to implementation and acceptance, rather than impact.
Where impact is measured, it is often short term rather than long term impact. Scope of practice changes tend to be more widely accepted when the health profession transferring the scope have accepted that their profession does not have the capacity or interest in continuing to provide these tasks. This means many scope of practice changes are proposed in a hostile environment.

With the many regulatory, financial, professional and behavioural changes required to effect such changes to scope, the extent that competency frameworks have a role in facilitating them is unclear.

### 3.2 Consultation feedback

**Healthcare needs and roles and activities of pharmacists**

Consultation questions to explore the current and future healthcare needs of the community, and the future roles and activities of pharmacists, were open-ended. This allowed responses to be provided without being restricted by pre-conceived perspectives.

**Organisations in the health sector.** Organisations in the health sector (outside pharmacy organisations) responding to the online survey identified the following current and future healthcare needs of the community that need to be considered in the review of the competency framework:

- Chronic health burden, requiring competencies in preventative health, health promotion, public health, history taking, monitoring, medication review and compliance upon discharge of patients from hospital
- Access to healthcare and advice (after hours, online, by phone), including triaging (e.g. with minor ailments), recognising and responding to access to internet-obtained information by the public leading to misinformation/misinterpretation, and the use of telehealth.
- Healthcare provided in the community, e.g. aged care, community based palliative care, requiring competencies in patient-centred care and being patient advocates, as well as facilitating self-management. Providing services in the context of schools, ‘Mums and Bubs’ groups and nursing homes were identified as a need.
- Team based health care and interprofessional collaboration, including public/private sector collaboratives
- Medication expertise, including in relation to substance abuse and antibiotic resistance
- Flexibility in who can provide healthcare, particularly with a dispersed population. This may include protocol/careplan driven management of patients, use of automated dispensing, and reliance on support workers (e.g. technicians). Skills in supervision and delegation will be important.
- Cultural diversity, including Indigenous, migrant and refuge health

Delivery of ‘Just in time, just for me’ healthcare was expressed.

It was expressed, however, that the competency framework should avoid being overly explicit about specific healthcare needs, because ‘the increasing complexity of patient care requires pharmacists to apply themselves to a wide range of co-morbidities and disease states. Instead, focusing on patient-centred care and ‘soft skills’ such as team work, leadership and communication should provide pharmacists with the capacity to enhance their knowledge and expand their competency as healthcare needs change’.
In relation to the role of pharmacists, it was expressed that, with the expanding scope of practice of pharmacists occurring internationally (e.g. adapting/modifying prescriptions, authorising prescription refills, administering injections, ordering and interpreting laboratory tests, initiating prescriptions in certain circumstances), there should be increased emphasis on patient-centred care, critical thinking, evidence-informed decision-making, leadership and communication. The ability to take action, rather than just provide recommendations, should be incorporated. The importance of interprofessional collaboration, particularly if making independent prescribing decisions, was also noted.

The role of pharmacists as ‘information assimilators’ was identified – acting as a patient advocate to help them navigate the increasingly complex health care system, including preventing system errors, miscommunication and the inappropriate use of resources. Increased autonomy for pharmacists in the community setting was expressed as a need. The ability to successfully negotiate with medical specialists was identified as important.

Future roles for pharmacists that were identified by respondents in the online survey included:

- Advanced monitoring and point of care testing, e.g. for diabetes – visual acuity, neuropathy screening (single filament test). Quality assurance of equipment and communication of results to all members of the team would need to be encompassed.
- Simple diagnosis
- Prescribing, including autonomous prescribing
- Vaccination
- Wound care.
- A focus on certain population groups, e.g. ageing population.

**Pharmacy organisations.** Pharmacy organisations responding to the online survey identified similar current and future healthcare needs of the community that need to be considered in the review of the competency framework, however further expanded on how pharmacists could contribute to addressing these needs. One respondent expressed ‘The future of pharmacy is in the provision of professional pharmacy services directed to improving health outcomes in patients and populations. These services will occur across the spectrum of health care from prevention to primary care through secondary and tertiary and include direct treatment. It will involve working collaboratively with all other healthcare workers’.

Expanding on those aspects identified by other organisations in the health sector, the following pharmacist roles were also identified:

- Complex care management outside of medication needs. It was expressed that there is not enough emphasis on conditions/disease and their management (with or independent of medicines use). The contribution of this to public health was noted, including managing multiple morbidities within the ageing population, dementia, obesity. Treatment planning, with client engagement was identified as a need. Monitoring the health impact of medicines (e.g. INR, BP, HbA1c) was also identified.
- Primary health care and the treatment of minor ailments. First aid, including emergency response, resuscitation and mental health first aid, were identified as important in reflecting the full scope of current pharmacists’ roles.
- Preventative health roles should be expanded. Screening and risk assessment services, as well as consideration of roles in pandemics and epidemics.
The provision of pharmacy services, requiring skills associated with the development, implementation, provision, evaluation and continuous improvement, and management of the service. This was expanded to consider management of multi-purpose and multi-site pharmacy services in line with implied and explicit service agreements.

Clinical services need to be expressed without regard for context (e.g. home, residential care, GP surgery, primary care setting, community pharmacy, hospital). Activities include medication histories and reconciliation, medication review, medication action plans. Advice on the use of genomic and customised medicines and ‘precision prescribing’ is a need. Advice on the use of new technologies, such as 3-D printing, should also be considered.

A focus not just on services provided to the individual, but to a group or cohort, should also be emphasised (e.g. drug and therapeutics committees in hospitals, medication advisory committees in residential facilities, drug usage evaluations, preparation of treatment guidelines for groups/cohorts). Ethics regarding allocation of resources and the use of medicines and support for clinical trials were also noted. Risk-benefit and cost-benefit analysis was identified as needing consideration.

The delivery of services through e-health and telehealth initiatives/platforms needs to be encompassed. Consideration of the impact of IT and social media was identified as a need.

Teaching and training activities were identified as needing focus, with consideration of the National Clinical Supervision Competency Resource.

**Individual practitioners.** Individual practitioners responding to the online survey also identified similar current and future healthcare needs of the community that need to be considered in the review of the competency framework, however responses were less comprehensive. The ageing population (and associated increase in those living in the community) and increased rates of chronic disease were the most commonly identified community need. The unmet demand for GP services, particularly in rural settings was also identified as a need that required consideration.

The need to work alongside others, particularly in rural and remote areas and with people from different ethnic backgrounds, was reinforced in the interview with the key opinion leader.

When asked to identify future roles/activities for pharmacists, the predominant themes identified by individual practitioners was an increased engagement with consumers, GPs and other healthcare providers to inform the optimal use of medications. This included:

- A presence in the primary care settings (e.g. GP surgeries) to conduct medication reviews and educate patients
- Greater engagement with GPs in relation to disease and medication management (with a number of respondents suggesting an approach more like it is in hospitals)
- Provision of screening activities and immunisations
- Prescribing
- Increased role as a partner in disease management, rather than just dispensing medicines.

A summary of the themes relating to the healthcare needs and pharmacist roles that were identified in the online survey and consultation forums, and the associated related competencies, are summarised in Table 9.
Table 9. Themes relating to healthcare needs and pharmacist roles identified in the consultation feedback

<table>
<thead>
<tr>
<th>Healthcare need</th>
<th>Pharmacist roles/activities</th>
<th>Related competencies identified as requiring focus</th>
</tr>
</thead>
</table>
| Healthcare needing to be accessible and ‘met in the community rather than an institution’ (e.g. with aging population, community based palliative care, rural settings, schools, community groups) | ■ Triaging  
■ Supporting continuity of care  
■ Providing professional services beyond pharmacy premises, including GP surgeries (level of autonomy may require credentialing consideration) | ■ Patient-centred care  
■ Self-management  
■ Interprofessional communication and teamwork  
■ Telehealth  
■ Primary healthcare  
■ Critical thinking, professional judgement, evidence-informed decision making, taking action (not just providing recommendations)  
■ Documentation and using technology (e.g. electronic records) throughout the practice environment  
■ Leadership and innovation |
| Increasing accessibility of information (e.g. internet-obtained)                 | ■ Health education/advice for consumers (‘information assimilator’)                        | ■ Communication |
| Increasing chronic disease                                                      | ■ Point of care testing  
■ Ordering and interpreting pathology tests  
■ Initiating, adapting/modifying, and/or authorising refills of prescriptions (level of autonomy may require credentialing consideration)  
■ Follow up of patients  
■ Protocol/careplan driven management of patients  
■ Medication adherence  
■ Medication review | ■ Health promotion  
■ Preventative healthcare  
■ Patient-centred care  
■ Self-management  
■ Interprofessional communication and teamwork  
■ Critical thinking, professional judgement, evidence-informed decision making; taking action (not just providing recommendations)  
■ Communication  
■ Documentation and using technology (e.g. electronic records) throughout the practice environment |
<table>
<thead>
<tr>
<th>Increased reliance on support workers</th>
<th>Supervision and delegation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased cultural diversity (e.g., migrant, refuge, Indigenous health)</td>
<td>Cultural competence</td>
</tr>
<tr>
<td>Public health needs</td>
<td>Vaccination</td>
</tr>
<tr>
<td></td>
<td>Screening activities</td>
</tr>
<tr>
<td></td>
<td>Health promotion</td>
</tr>
<tr>
<td></td>
<td>Administering medicines via injections</td>
</tr>
<tr>
<td></td>
<td>Physical contact</td>
</tr>
<tr>
<td>Changing technology</td>
<td>Automated dispensing</td>
</tr>
<tr>
<td></td>
<td>Using IT appropriately to support expanded practice, identifying and addressing barriers to patient care arising from IT, recommending appropriate IT</td>
</tr>
</tbody>
</table>

**Prioritising areas of focus in reviewing the current competency framework**

Feedback provided in the online survey and during the consultation forums did not identify a need for a fundamental change to the content of the competencies in the current framework (‘no glaring gaps’, ‘nothing that is not covered’; also see Figure 5). However, it was noted that the Domains as they currently stand will probably not accommodate the changes that are required, and so these ‘will need to be redefined/replaced. Some elements of the 8-star pharmacist could be used to inform the development of a revised framework, but they are not sufficient in themselves.’ An evolutionary approach to amendments was proposed, with integration and contextualisation further assisted by a change to focus on the observable behaviours (identified in Part 2 above).

Respondents to the online survey were asked to consider the current National Competency Standards Framework for Pharmacists in Australia. For each competency, they were asked to identify whether they agreed it continues to be appropriate or whether it needs to change. Options of retained, retained but with modification or deleted were offered. Figures 27-34 reflect the responses, according to the current Domains in the competency framework.
Organisations in the health sector. Organisations in the health sector (outside pharmacy organisations) responding to the online survey expressed a need in Domain 1 for further emphasis on ethical obligations, particularly regarding conflict of interest.

A greater focus on patient-centred care was also expressed by a number of respondents. It was noted that as ‘pharmacy practice evolves internationally to focus more on direct patient care and take a more active role in patient care, the term consumer may imply an earlier view of pharmacy and the term ‘patient’ [rather than ‘consumer’] may better reflect emerging pharmacy practice’. Further, it was noted that there are many models and principles for what constitutes patient-centred care; one respondent expressed a preference for the Picker Principles of Patient-centred Care. Consideration for the community, not just the individual, was also expressed.

Other suggestions involved:

- Further emphasising quality improvement/quality assurance by separating it into its own domain
- Including risk management activities (e.g. identifying high risk processes and high risk drugs)
- An emphasis on the importance of sharing ‘lessons learned’ and resolutions following medication incidents.
- Maintaining professional competence should be delineated from extending professional competence (i.e. extending competence should not be a requirement for practitioners to demonstrate competence with the profession).

Some respondents expressed that the current statements are too short and do not provide a suitable framework for accountable practice or measurement. One respondent proposed the following statements:

1.1 Maintains practice in accordance with the legal and ethical standards that apply to the profession;
1.2 Practises with an evidence based framework;
1.3 Provide care through effective partnerships with consumers and carer;
1.4 Manage the environment and practice within recognised quality and safety standards.
Pharmacy organisations. Pharmacy organisations responding to the online survey expressed similar views to other health organisations in the health sector in relation to Domain 1, specifically:

- Inclusion of a competency standard relating to ethical practice
- Increased emphasis on patient-centred care across all Domains (particularly Domain 6) and with a 2015 perspective
- Language to assist pharmacists better understand the expectations for maintaining professional competence, with a suggestion to consider the term ‘professional development’ or lifelong learning
- Modification across all competency standards to include the provision of services rather than being product focused.

Individual practitioners. Individuals responding to the online survey expressed a desire for:

- A better definition of patient-centred care
- A need to modify the language to better reflect the breadth of pharmacy practice (i.e. not so community pharmacy focused)
- An increased emphasis on a high level of ethical and professional practice (not just a minimum acceptable standard).

Domain 2

Figure 28. The continued appropriateness of the competencies in Domain 2 of the current competency framework for pharmacists in Australia
Organisations in the health sector. Organisations in the health sector (outside pharmacy organisations) responding to the online survey expressed:

- The focus of Domain 2 should be communication and team work. There should be greater emphasis on collaboration, modes of communication, working to resolve problems, assimilating information and resolving complex issues as a patient advocate. The inclusion of competency standards 2.5-2.7 ‘waters down’ this focus, and would be better placed in Domain 3.

- A need to further emphasise competencies related to information technology, including using it properly, identifying and addressing barriers to patient care that arise from it, recommendations for appropriate use by others. Newer forms of media and communications should be included.

- Inclusion of competencies about pharmacists proactively seeking out and establishing collaborative relationships with other health care professionals.

- Expansion of the term ‘care team’ to explicitly include the individual receiving the care and their carer/family members involved in their care, and clarification such as whether this is the primary care team, the acute team, etc.

- A strengthening of English language requirements, with one respondent noting that too many students are graduating with unacceptable English standards

- Inclusion of cultural awareness when communicating

- ‘Supervise’ is a relative old fashioned concept, with a preference for ‘mentor’, ‘develop’ or ‘oversee’.

- An increased emphasis on patient-centred care.

Pharmacy organisations. Pharmacy organisations responding to the online survey expressed similar views to other health organisations in the health sector in relation to Domain 2, specifically:

- Removing the focus of communication relating to a ‘workplace’, and rather moving the focus to be on the consumer (i.e. consider the division of Carer and Manager in the 8-star pharmacist)

- Consideration that the supervision of personnel may not be applicable in all contexts, particularly for pharmacists working in new or expanding roles, e.g. consultants

- Inclusion of competencies surrounding being able to work as part of a team, e.g. developing a team, managing team dynamics, and building a professional team culture

- Inclusion of cross cultural communication

- Language modified so that they can be assessed or measured.

Individual practitioners. Individuals responding to the online survey also identified that the communication competencies were expressed in a way that limited context, with conflict management and staff management/supervision not been relevant to pharmacists outside a workplace. It was recommended that communication skills need to address all audiences (patients, customers, health professionals, GPs) and reflect different work environments. Other suggestions included:

- Extension of the competencies to support collaboration with other health care team members, including negotiation and problem solving, and initiation of engagement

- It was noted that the competencies appear to be a mix of patient/care focused (2.1-2.3) with HR and business focused (2.4-2.7). Amalgamation of workplace/work relationship competencies was proposed.
Figure 29. The continued appropriateness of the competencies in Domain 3 of the current competency framework for pharmacists in Australia

<table>
<thead>
<tr>
<th>Standard 3.1 Provide leadership and organisational planning</th>
<th>Individual</th>
<th>Non-pharma</th>
<th>Pharma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard 3.2 Manage and develop personnel</td>
<td>Individual</td>
<td>Non-pharma</td>
<td>Pharma</td>
</tr>
<tr>
<td>Standard 3.3 Manage pharmacy infrastructure and resources</td>
<td>Individual</td>
<td>Non-pharma</td>
<td>Pharma</td>
</tr>
<tr>
<td>Standard 3.4 Manage quality service delivery</td>
<td>Individual</td>
<td>Non-pharma</td>
<td>Pharma</td>
</tr>
<tr>
<td>Standard 3.5 Provide a safe and secure work environment</td>
<td>Individual</td>
<td>Non-pharma</td>
<td>Pharma</td>
</tr>
</tbody>
</table>

**Organisations in the health sector.** Organisations in the health sector (outside pharmacy organisations) responding to the online survey expressed that the competencies in Domain 3 ‘came across more clearly’. Respondents identified that consideration should be given to:

- Competencies relating to supervising, auditing and reconciling inventory, specifically for controlled substances
- Competencies related to creating policies and procedures for evaluating quality of products received, dealing with drug shortages and further emphasising cold chain management responsibilities
- Innovation in the sector, which will be a vital part of the health care professional of the future in creating new roles to address identified needs.

The need for pharmacists to be innovative in driving new roles to address identified needs was reinforced in the interview with the key opinion leader.

**Pharmacy organisations.** Pharmacy organisations responding to the online survey queried the relevance of aspects of management in Domain 3 (e.g. management of infrastructure and personnel) for pharmacists in expanded roles (e.g. outside of a workplace).

Concern was expressed that the competencies are too specific in this Domain, which results in too many gaps, e.g. it does not sufficiently cover basic business principles and grounding in health retailing. It was suggested that this Domain needs to either be more general (and so flexible, e.g. to allow for business CPD to be accredited) or much more detailed.

**Individual practitioners.** Individuals responding to the online survey also queried the applicability of competencies in Domain 3 to the different roles and experience of pharmacists. It was expressed that it needs to be clear what level of practitioner these competencies apply to, noting that the development of these skills does not occur at undergraduate level. It was also noted that, in some service contexts, these are
not competencies required of pharmacists (i.e. development and management of personnel, infrastructure and resources).

One respondent suggested that modification of 3.4 Manage quality service delivery should be considered to reflect the increasing role in quality programs and reference to national safety and quality standards.

**Domain 4**

Figure 30. The continued appropriateness of the competencies in Domain 4 of the current competency framework for pharmacists in Australia

**Organisations in the health sector.** Organisations in the health sector (outside pharmacy organisations) responding to the online survey expressed that these appeared to be ‘more actions than standards’. They are ‘very prescriptive, maybe even restrictive’. It was expressed that Domain 4 appeared to reflect the pharmacist’s role as supply/dispense heavy, and indicated that this was not desirable for future pharmacists. The importance of information assimilation (e.g. history checking from multiple sources) was noted as where pharmacists skills optimally lie, with much of the other activities being able to be provided by others in the pharmacy workforce (e.g. technicians).

This was further emphasised in the international context, where the competencies for pharmacists in Canada have tried to ‘minimise pure product distribution competencies’, while emphasising the responsibilities of pharmacists around assessing the appropriateness of the prescription. The overlap of these medication management competencies with those in Domain 7 was noted.

Other views expressed include a need to:

- Acknowledge that the assessment/review process is ongoing (not limited to the initial step)
- Increase emphasis on liaison with the health care team if required
- Document the role of support staff
- Allow for prescribing from a limited formulary.

**Pharmacy organisations.** Pharmacy organisations responding to the online survey suggested:

- The role of pharmacists has moved away from a product focus and mere supply of pharmaceutical products. The term ‘dispense’ should be reviewed and better defined, and Domain 4 could be expanded to include administration of medicines.
- The use of technology, e.g. electronic transfer of prescriptions and use of patient controlled electronic health information, be included.
Competency standards 4.2 has a medicines focus, but should be focused on the patient.

Competencies relating to the provision of dose administration aids, including internal and external provider procedures, should be included.

Individual practitioners. The predominant concern of individuals responding to the online survey was in relation to modifications required to move the focus from dispensing to medication management. Other suggestions expressed were:

- Inclusion of the use of technology (e.g. computing and software competence)
- Inclusion of the competencies associated with prescribing
- Consideration of the applicability to roles outside a dispensing pharmacy
- Reference to supervision of dispensing (e.g. technicians, automated dispensing)
- The provision of advice, education and counselling being part of the dispensing competency.
- Reference to legislation and standards when using terms like ‘appropriate’.

Domain 5

Figure 31. The continued appropriateness of the competencies in Domain 5 of the current competency framework for pharmacists in Australia

Organisations in the health sector. Organisations in the health sector (outside pharmacy organisations) responding to the online survey suggested:

- Consideration incorporating these competencies within the Domain 4, encompassing the supply of all products, not just those compounded or aseptically prepared.
- Consideration of whether this is a specialist or advanced practice area that a minority of practitioners utilise
- Whether the term ‘hazardous’ is more appropriate than just ‘cytotoxic’
- Competency standards 5.3 and 5.4 being dependent on the work site, and therefore requiring specific standards
- The need to retain knowledge about all of these areas, even for those not involved in preparation.

Pharmacy organisations. Pharmacy organisations responding to the online survey expressed:
A greater emphasis on the overall concept of quality assurance and management was needed.

This is the core of pharmaceutical skills, and should be recognised and valued.

The usual work of pharmacists no longer requires knowledge of preparation of pharmaceutical products as a primary function, and so it should become an area of specialisation.

For competency standard 5.4, knowledge of, rather than demonstrated skill, is appropriate.

**Individual practitioners.** The predominant concern of individuals responding to the online survey was who the competency should apply to, rather than the actual content. It was expressed that they were not applicable to all workplaces or practitioners, and that they could potentially become an ‘advanced practice’ competency. Terminology was queried (drug versus medicine). The need to reference the physical/environmental requirements, as well as the individual’s competency was noted.

**Domain 6**

Figure 32. The continued appropriateness of the competencies in Domain 6 of the current competency framework for pharmacists in Australia

**Organisations in the health sector.** Organisations in the health sector (outside pharmacy organisations) responding to the online survey expressed that it was difficult to understand the outcomes that a pharmacist contributes in Domain 6, and it needed to be reviewed to give it more meaning and structure. Other suggestions included:

- Focusing not only on optimal therapeutic outcomes, but on the patient’s health goals, which might differ depending on the patient.
- Renaming Domain 6 to just ‘Primary Health Care’, as prevention should be implicit here.
- Adding competencies relating to working with health services on collaborative programs to improve health outcomes.
- Including competencies relating to immunisation services, responding to emergencies (e.g. disaster, pandemics), targeting health promotion activities to a specific patient (not just participating in public health initiatives), minimising the risk of disease transmission from the pharmacy, and promoting the proper disposal of drugs and hazardous products by the patient (reducing environmental contamination).
- Including competencies relating to keeping proper records of patient interactions and decisions like any other health professional.
Pharmacy organisations. Pharmacy organisations responding to the online survey expressed:

- A greater emphasis on recording is required
- Pharmacists being more proactive in engaging consumers in primary healthcare activities (good approach to OTC and complaints described, but role in preventative health is less clear).

Individual practitioners. Individuals responding to the online survey expressed a need to better define and describe primary care. A greater emphasis on a collaborative approach and the role of a clinical pharmacist was identified, with suggestions that descriptions be broadened to include existing activities (e.g. HMR) and allow for expanded roles (e.g. screening, vaccination). An increased emphasis on evidence based care was also noted as needed.

Domain 7

Figure 33. The continued appropriateness of the competencies in Domain 7 of the current competency framework for pharmacists in Australia

Organisations in the health sector. Organisations in the health sector (outside pharmacy organisations) responding to the online survey expressed that there was overlap with Domain 4, with a suggestion to rename this Domain as ‘Quality Use of Medicines’ (broader, less restrictive).

It was expressed that follow up with all patients should be expected, even if just a quick, short follow up to determine all is going well. As such 7.2.1.1 would not apply.

One respondent noted that this Domain requires better government recognition of the pharmacy role and greater autonomy.

Pharmacy organisations. Pharmacy organisations responding to the online survey expressed a need for:

- Competencies in continuity of care practices, e.g. medication reconciliation, clinical handover between pharmacists
- A competency in the provision of holistic patient-centred care
- Descriptors to use language such as ‘Demonstrate’, rather than ‘Having the ability’.

Individual practitioners. Individuals responding to the online survey identified an overlap of Domain 7 with Domains 4 and 6. It was suggested that competencies be modified to reflect:

- Involvement in multidisciplinary care and closer collaboration with GPs (e.g. in GP surgeries)
- Services being provided to any setting (not restricted to community and hospital)
Reference to medication history, assessment, review, management of multiple conditions and engaging multiple providers

An increased focus on evidence-based, patient-centred care.

Domain 8

Figure 34. The continued appropriateness of the competencies in Domain 8 of the current competency framework for pharmacists in Australia

Organisations in the health sector. Organisations in the health sector (outside pharmacy organisations) responding to the online survey expressed:

- Re-naming the Domain to ‘Research and Education’
- In 8.2, there may be value in expanding this to be not just about conducting research, but also in participating in research developed and conducted by others (i.e. agreeing to participate in pharmacy practice research to see if pharmacist interventions are effective)
- Emphasis that this is not just about research, but evidence-based medicine
- This is possibly not a core function or appropriate for some pharmacists, so could be optional.

Pharmacy organisations. Pharmacy organisations responding to the online survey expressed that interprofessional education is an essential ingredient to the success of integrated service models and needs to start at University with champions continuing through CPD. Appraising literature and presenting it is a skill by itself and should happen more often in the context of interprofessional education.

Individual practitioners. Individuals responding to the online survey expressed that:

- These are not standards expected of an entry-level practitioner
- There is overlap between competency standard 8.1 and ‘standard’ medication review activities
- Domain 8 should be updated to reflect access to internet information and tools (by pharmacists and the public).
Discussion in the consultation forums was consistent with many of the views expressed through the online survey, and supported clarification of priority areas for the review of the current competency standards framework. These are identified below.

1. **Patient-centredness**

Patient centred care was described in the feedback as ‘an element that runs like a piece of string throughout the whole set of standards’. Many respondents proposed patient-centredness needed greater emphasis/prominence than just its inclusion as competency standard 1.3 Deliver ‘patient-centred’ care, such as by:

- Referring to patients, rather than consumers, to better reflect the move internationally of pharmacists taking an active role in direct patient care (and moving away from earlier views of pharmacy)
- Naming domains and competencies in a manner that reflected the impact on, or value to, the patient, wherever possible (even when a pharmacist is removed from the direct patient care, e.g. at the systems level). For example, one respondent stated Domain 6 ‘needs to be totally reworked to give it more meaning and structure. [It] is too weak and hard to understand what outcomes the pharmacist can contribute’.
- Integrating patient-centred care to all roles/activities. This includes not separating patient care from primary/preventative care, as well as recognising behaviours may be different in the patient context for the same competency (e.g. when comparing communication with health professionals to communication with patients)
- Incorporating competency standard 1.3 Deliver ‘patient-centred’ care into Domain 7
- In Domain 6, moving the focus from achieving optimal therapeutic outcomes to achieving the patient’s health goals, which may differ depending on the patient.

Some respondents reported wanting to see patient-centred care expanded further, e.g. including carers. Reference to the Picker Principles of Patient-Centred Care was made; the primary dimensions of patient-centred care being:

- Respect for patients’ values, preferences and expressed needs
- Coordination and integration of care
- Information, communication and education
- Physical comfort
- Emotional support and alleviation of fear and anxiety
- Involvement of family and friends
- Transition and continuity.

This may be further expanded when the World Health Organization definition of ‘people-centred care’ is considered, which is ‘care that is focused and organized around the health needs and expectations of people and communities rather than on diseases. People-centred care extends the concept of patient-centred care to individuals, families, communities and society. Whereas patient-centred care is commonly understood as focusing on the individual seeking care—the patient—people-centred care encompasses these clinical encounters and also includes attention to the health of people in their communities and their crucial role in shaping health policy and health services’. A domain titled ‘Meeting community needs’ was proposed.
2. Flexibility in context and setting

While recognised as a focus of the previous review of the competency framework, a continuing effort to remove references that may limit the context and settings of pharmacist services was identified as a need. This, however, needs to be balanced with ensuring the framework still reflects the profession for those outside the profession.

A change in language from workplace (‘bricks and mortar’) to environment (where a person delivers service or practices) was proposed. Reflecting domains in terms of the professional role (e.g. using the medication management pathway\(^{81}\) for guiding the structure of the competency framework in a patient-centred way) was also proposed. Other specific feedback provided included:

- In Domain 2, competencies 2.4 Manage conflict, 2.5 Commitment to work and the workplace, 2.6 Plan and manage professional contribution, and 2.7 Supervise personnel are too heavily focused on a ‘workplace’ setting. It was expressed that the focus of this domain should be on communication and collaboration, with increased emphasis on such things as listening, teamwork and problem resolution as a patient advocate. This could be further extended to competencies about proactively seeking out and establishing relationships with other health professionals. Competencies 2.4-2.7 were proposed to be better placed in the domain relating to management.

- The contents of Domain 4 could be captured within a Domain on medication management (e.g. Domain 7), removing the focus on the setting for dispensing (which could be undertaken by a technician), and increasing the focus on the professional role (e.g. information assimilation, history checking, prioritising drug related problems, monitoring effect of dispensed medications).

- The contents of Domain 4 and 5 could be incorporated into a Domain on medication supply. Preparation of a product should be considered in the context of its appropriateness for the individual. This could encompass competencies relating to drug shortages, cold chain management, evaluating the quality of stock received, using quality assurance techniques such as visual inspection, use of manufacturer quality markers, ensuring legitimate suppliers, etc.

- Domain 6 is too medicine-centric. With emerging roles involving the management of conditions independent of the supply of medicines (e.g. screening and risk assessment services), the competencies need to better reflect this.

- Including competencies that reflect roles are being undertaken outside a workplace setting, so consideration of self-safety and patients’ cultural safety and mental health is required.

3. Management and leadership

Recognition of the difference between management and leadership was identified as a need. It was noted Domain 3 was written to suit the roles of pharmacy at the time, but needed significant work now. Management aspects needing strengthening included quality assurance, continuous improvement and business management, with expectations of competencies required for a pharmacist at initial registration needing greater clarity.

Leadership competencies need to reflect clinical leadership, and the responsibility to be a role model to younger pharmacists, also need strengthening.
4. Education and research

Education and research as separate Domains was proposed by some respondents, to better reflect the different activities.

In relation to research, it was proposed that competencies for participating in research developed and conducted by others, and not just conducting own research, should also be included.

One respondent stated that Domain 8 was ‘possibly not a core function or appropriate for some pharmacists [and] could be optional’. This may be a reflection of the language used, which may not facilitate understanding of the types of roles and activities undertaken by all pharmacists.

5. Expectations for preparing pharmaceutical products

There were divergent views expressed in relation to the inclusion of preparation of pharmaceutical products. Some respondents considered it a basic requirement for pharmacists, while others considered it a specialist or advanced area of practice. Clear expectations of competencies required for a pharmacist at initial registration in contrast to those pharmacists compounding extensively was identified as a need.

**Recommendation 7.** Give greater prominence to people-centred care.

- Use language for domains and competencies that reflects the value to, or impact on, the patient or community (e.g. achieving ‘patient’s health goals’, rather than ‘optimal therapeutic outcomes’).
- Refer to patient-centred care throughout the framework (e.g. not just in competency standard 1.3).

**Recommendation 8.** Reflect the pharmacist’s contribution to patient or community outcomes without regard for context and setting

- Choose terms that reflects pharmacists having an active and direct role in patient care (e.g. ‘patients’, not ‘consumers’).
- Choose terms that do not limit the context and settings of pharmacist services (e.g. ‘environment’, not ‘workplace’).
- Retain the grouping of competencies into domains that are areas of professional responsibility (not roles). With particular consideration of Domains 4, 5, 6 and 7, structure them to better reflect the professional contribution made by pharmacists to patients or the community (e.g. capturing competencies for dispensing and preparing pharmaceutical products within a domain relating to medication management to remove focus on the setting for dispensing, while increasing focus on the professional role rather than those that could be substituted by a technician). Names should reflect emerging and future roles, rather than traditional roles.
- Use language for domains and competencies that has meaning to those outside the profession (e.g. amend the language used for the domain and competencies in Domain 6 ‘Delivery primary and preventative healthcare’).
**Recommendation 9.** Review the management and leadership competencies (Domain 3).
- Recognise that management and leadership are different areas of responsibility or professional endeavour and may not be appropriate to group together in one domain.
- Consider existing competencies, with particular consideration of performance expectations. Distinguish those that should be encompassed with a Competence Framework (including consideration of those required for initial registration in contrast to those that reflect an individual’s scope of practice post-registration) and those that may be better incorporated in a Performance Framework.

**Recommendation 10.** Review the education and research competencies (Domain 8).
- Recognise that education and research are different areas of responsibility or professional endeavour and may not be appropriate to group together in one domain.
- Consider existing competencies, with particular consideration of performance expectations. Distinguish those that should be encompassed with a Competence Framework (including consideration of those required for initial registration in contrast to those that reflect an individual’s scope of practice post-registration) and those that may be better incorporated in a Performance Framework.

**Recommendation 11.** Incorporate competencies required for roles/services being undertaken outside a workplace setting, e.g. self-safety, patients’ cultural safety and mental health.

**Recommendation 12.** Incorporate competencies required for health management independent of the use of medicines, e.g. for self and patient physical comfort during screening, monitoring and administration services.

**Recommendation 13.** Ensure observable behaviours for all competencies reflect changing technology (both self-use and patient use)

**Recommendation 14.** Ensure observable behaviours for all competencies describe the pharmacist as an active member in a healthcare team with responsibility and accountability.
- Emphasise behaviours associated with critical thinking, professional judgement, evidence-informed decision making, taking action (not just providing recommendations), follow up of patients, documentation and communication to support transition and continuity of care.
4. Goals and recommendations

A consolidated list of recommendations, grouped according to overarching goals, are provided to guide medium to long term planning of future competency standards models for the Australian pharmacy profession.

Goal 1. A competency framework model that is structured in a way that meets the needs of all users.

Recommendation 1. Structure the framework to support alignment across the many purposes for which the framework is used.

- Define ‘competent’ as a point on a curve of improving performance. For any specified competency, ‘competent’ is the level of performance required to be eligible for initial registration as a pharmacist, and/or is the minimum level of performance that must be retained for continuing registration.

- Develop an overarching framework that identifies competencies for varying scopes of practice and supports recognition of varying levels of performance (including for credentialing/privileging processes).

- Agree on those components that are central to all users. Develop a Competence Framework to describe competent performance, while higher levels of performance (the ‘performance continuum’) should be described in an aligning Performance Framework. Guidelines and tools specific to particular users may sit in supporting documents (i.e. for contextualisation and translation).
Recommendation 2. Describe competencies in terms of observable behaviours.

- Describing competencies in terms of observable behaviours will support an objective assessment of performance while valuing the inherent integration of tasks and complex conceptual, analytical and behavioural functions that underpin professional service delivery. It should improve the practical value of the framework by reducing bulkiness and fragmentation.

- Retain the level of detail necessary to support understanding of relevance, without being prescriptive and restricting flexibility and innovation.

- With reference to the current competency framework, this can be achieved by reducing the number of levels in the framework, consolidating Elements and Performance Criteria into Observable Behaviours.

Recommendation 3. Retain only markers of good behaviour in the competency framework, and not markers of poor.

- Ensure behaviours are sufficiently descriptive to assist in providing feedback and help insight into behaviour, without defining poor behaviours.

- Consider the development and use of markers of poor behaviours in performance management tools.

Recommendation 4. Retain grouping competencies according to domains (areas of professional responsibility).

- Review the naming and grouping to better reflect the emerging and future roles and responsibilities (discussed further in Part 3 of this report).

Recommendation 5. Initiate discussions with other healthcare professions with a medium to long-term goal of developing a common structure and consistent terminology for the competency frameworks of all healthcare professions.

Recommendation 6. Achieve effective implementation by developing a whole-of-profession communication and implementation plan.

- Development of the plan should:
  - Involve representatives of all users of the document, across all purposes for which the framework is to be used.
  - Identify mechanisms for developing consistent guidance material and tools on the development and use of the framework.

- The plan should prioritise:
  - A review of the Customised Entry-level Competency Tool for Pharmacists, given the reported value of the competency framework in the development of education leading to initial registration.
  - Engaging individual practitioners in using the Competence Framework and Performance Framework.
  - Mechanisms for demonstrating competence in, or capability for, extended scopes of practice.
Goal 2. A framework that is focused and organised around the health needs and expectations of people and communities


- Use language for domains and competencies that reflects the value to, or impact on, the patient or community (e.g. achieving ‘patient’s health goals’, rather than ‘optimal therapeutic outcomes’).
- Refer to patient-centred care throughout the framework (e.g. not just in competency standard 1.3).

Recommendation 8. Reflect the pharmacist’s contribution to patient or community outcomes without regard for context and setting

- Choose terms that reflects pharmacists having an active and direct role in patient care (e.g. ‘patients’, not ‘consumers’).
- Choose terms that do not limit the context and settings of pharmacist services (e.g. ‘environment’, not ‘workplace’).
- Retain the grouping of competencies into domains that are areas of professional responsibility (not roles). With particular consideration of Domains 4, 5, 6 and 7, structure them to better reflect the professional contribution made by pharmacists to patients or the community (e.g. capturing competencies for dispensing and preparing pharmaceutical products within a domain relating to medication management to remove focus on the setting for dispensing, while increasing focus on the professional role rather than those that could be substituted by a technician). Names should reflect emerging and future roles, rather than traditional roles.
- Use language for domains and competencies that has meaning to those outside the profession (e.g. amend the language used for the domain and competencies in Domain 6 ‘Delivery primary and preventative healthcare’).
Goal 3. Competencies for contemporary and future pharmacy practice

Recommendation 9. Review the management and leadership competencies (Domain 3).

- Recognise that management and leadership are different areas of responsibility or professional endeavour and may not be appropriate to group together in one domain.
- Consider existing competencies, with particular consideration of performance expectations. Distinguish those that should be encompassed with a Competence Framework (including consideration of those required for initial registration in contrast to those that reflect an individual’s scope of practice post-registration) and those that may be better incorporated in a Performance Framework.

Recommendation 10. Review the education and research competencies (Domain 8).

- Recognise that education and research are different areas of responsibility or professional endeavour and may not be appropriate to group together in one domain.
- Consider existing competencies, with particular consideration of performance expectations. Distinguish those that should be encompassed with a Competence Framework (including consideration of those required for initial registration in contrast to those that reflect an individual’s scope of practice post-registration) and those that may be better incorporated in a Performance Framework.

Recommendation 11. Incorporate competencies required for roles/services being undertaken outside a workplace setting, e.g. self-safety, patients’ cultural safety and mental health.

Recommendation 12. Incorporate competencies required for health management independent of the use of medicines, e.g. for self and patient physical comfort during screening, monitoring and administration services.

Recommendation 13. Ensure observable behaviours for all competencies reflect changing technology (both self-use and patient use)

Recommendation 14. Ensure observable behaviours for all competencies describe the pharmacist as an active member in a healthcare team with responsibility and accountability.

- Emphasise behaviours associated with critical thinking, professional judgement, evidence-informed decision making, taking action (not just providing recommendations), follow up of patients, documentation and communication to support transition and continuity of care.
Appendix 1

In preparing this consultation paper, competency frameworks for the following professions were selected for inclusion in the background review:

AUSTRALIA – Professions regulated under the National Law

- Aboriginal and Torres Strait Islander Practitioner
- Chinese medicine
- Chiropractor
- Dentist
- Medical practitioner
- Medical radiation practitioner
- Nurse and midwife
- Occupational therapist
- Optometrist
- Osteopath
- Physiotherapist
- Podiatrist
- Psychologist
- Surgeon

AUSTRALIA – Other professions/areas

- Aboriginal and Torres Strait Islander health
- Allied health
- Australian Public Service
- Cultural
- Dietitians
- Interprofessional
- Internal auditor
- Leadership
- Prescribing
- School counsellor

INTERNATIONAL – Health professions

- Interprofessional (Canada, United Kingdom, United States of America)
- Medical practitioner (Canada, United Kingdom)
- Patient safety (Canada)
- Pharmacist (Canada, England, Ireland, New Zealand, United States of America)
INTERNATIONAL – Other professions

- Government communication (United Kingdom)
- Social worker (United Kingdom)
- Graduate school (United States of America)
- Program and project management, Ministry of Justice (United States of America)

Endnotes

7. Pharmacy Board of Australia. Professional indemnity insurance arrangements standard. Available at www.pharmacyboard.gov.au
15. Accreditation Liaison Group. Accreditation within the National Registration and Accreditation Scheme. October 2014.
17. O’Keefe M, Henderson A, Pitt R. Health Medicine and Veterinary Science: Learning and Teaching Academic Standards. Learning and Teaching Academic Standards Project (support for the original work was provided by the Australian Learning and Teaching Council Ltd, an initiative of the Australia Government), Sydney: Australian Learning and Teaching Council, 2011.

Endnotes continued...
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