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AMA submission – PSA (pharmacists) professional practice standards version 5

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The AMA recognises the valuable contribution pharmacists make in providing high quality health care services, and working with medical practitioners and patients to ensure medication adherence, improve medication management, and provide education about medication safety.

The Pharmaceutical Society of Australia's (PSA) commitment to evolving and guiding the professionalism of pharmacists is welcomed and the professional standards as a whole set a high benchmark for providing quality, evidence-based patient care.

The AMA considers that some of the detail of the Standards could be further strengthened or clarified to enhance patient privacy, patient safety, the quality of patient healthcare and the collaboration between our two professions in providing person-centred care and services.

Our comments are detailed below.

Structure of the Standards

The AMA supports the revised structure of the Standards (Figure 2, page 8). The new structure reinforces that the interrelationship of the individual standards, and that the 'foundation' principles underpin the rest.

The AMA is pleased to see that the *Collaborative Care Standard* underpins the application of all the Professional Services standards.

Standard 1 – Fundamental pharmacy practice

1.2 Ethics and Professionalism
1.7 Quality Use of Medicines
1.8 Evidence-based Practice
1.9 Communication and Collaboration

The AMA advocates for evidence-based practice and the quality use of medicines. We commend the PSA for emphasising these as fundamental requirements of pharmacist practice.

The recent CHOICE report (*Is your pharmacist giving you the right advice? 13 February 2017*) indicated that nearly a third of Australian pharmacists sampled were recommending unproven complementary medicine products. This is concerning on many levels, including the fact that pharmacists were attempting to 'treat' a health condition outside their scope of practice.

It is also concerning that only 3% of 'shoppers' seeking advice for stress were referred to a general practitioner.

We applaud the PSA's response, publicly stating that these pharmacists are not adhering to the PSA's *Code of Ethics* or professional standards which require them to provide evidence-based advice and services in the best interests of patients.

Consistent with this stance, it should be a requirement under *1.8 Evidence-Based Practice* that pharmacists undertake to only supply products, complementary medicines, and services that have an evidence-base supporting their efficacy.

The unambiguous description of these fundamental requirements in Standard 1 will make it easier to hold pharmacists to account if their practises do not comply.

Consistent with the above concerns, the AMA recommends that a criterion is included under this Standard for pharmacists to report behaviour inconsistent with the Professional Practice Standards to the PSA to protect the broader professionalism of pharmacists and facilitate better education and training. The *AMA Code of Ethics* includes a similar requirement: Report suspected unethical or unprofessional conduct by a colleague to the appropriate peer review body (2.1.4).

1.3 Patient Privacy

The AMA is pleased to see *Privacy and Confidentiality* of the patient highly placed as a fundamental tenet of pharmacy practice.

However, the actions for this criterion should be strengthened to clarify that where pharmacists provide certain face-to-face services to patients, a private room should be available to protect the privacy and confidentiality of the patient.

Criterion 1.1 Patient-Centred Care, Action 1.3.1 is ambiguous because it is unclear whether the setting for information exchange and service delivery is intended to be 'appropriate' to the pharmacist or the patient. It should be clarified that the setting for information exchange and service delivery must be 'appropriate to the patient'.

Standard 3 - Dispensing and other supply arrangements

Timely, clear and consistent communication between the medical practitioner and the pharmacist is essential to improve patient care and enhance the professional medical practitioner/pharmacist relationship. This is particularly important where a medicine is dispensed without a medical practitioner's prescription.

Under Action 3.7.9, it should explicitly require the pharmacist to advise the prescriber about the emergency supply or 'continued dispensing' and within the timeframe set by their jurisdiction's legislation.

Standard 4 - Provision of non-prescription medicines and therapeutic devices

The AMA is pleased to see that Criterion 4.5.3 requires provision of non-prescription medicines and therapeutic devices consistent with contemporary evidence and practice guidelines.

There are two typographical errors: under 4.4.2 'evdience' should be 'evidence' and under 4.8.3 'complimentary' should be 'complementary'.

Standard 6 - Medication information

It is becoming more common for the Consumer Medication Information not to be provided with a patient's medications when they are dispensed. This has the potential to jeopardise patients' understanding of what adverse reactions they may experience in taking the medication. Patients should have ready access to information about their medications as part of making informed decisions about the management of their health. Standard 6 should be strengthened to ensure patients are provided either with the information directly or made aware of how to access such information.

Standard 7 – Health promotion and education

The AMA supports the role of pharmacists in contributing to patient's overall health as part of the healthcare team.

The criteria and actions are consistent with good practice, however, it should be clear that the role of pharmacists in health promotion and education is limited to a pharmacist's scope of practice, such as education in the safe and optimal use of medicines and other therapeutic goods, and does not extend into broader areas of health care.

Standard 10 – Screening and risk assessment

The AMA's comments under Standard 7 also apply to screening and risk assessment services. These services should also be limited to those that are within pharmacists' scope of practice.

In upholding principles of providing safe, evidence-based, effective and cost-effective services, pharmacists must limit screening and risk assessment to services to those that:

- provide a demonstrated benefit to patients (actually lead to better health care outcomes)
- complement and do not duplicate existing services provided by other health professionals or services (e.g. general practitioners, community-based clinics)
- do not lead to higher out-of-pocket costs for patients or higher costs to the health system as a whole

For example, it is not effective or cost effective for patients to receive 'skin spot' checks at pharmacies where patients self-determine the 'spots' to be 'checked', pay a fee to the pharmacist, and then must be referred to a general practitioner for a full skin check and treatment, or potential specialist referral. In cases where the self-determined spots are assessed as benign, patients have a false sense of assurance and do not seek a full skin check through their general practitioner.

Standard 11 - Vaccination services

The AMA does not support vaccinations being prescribed or administered by pharmacists who have not undertaken an appropriate level of accredited training. The provision of such services by providers other than the patient's usual GP practice facilitates the fragmentation of care. The PSA Standards should reflect that when a patient has a usual GP, they should be encouraged to seek these services as part of their regular GP visit, as immunisation attendance provides GPs with an excellent opportunity to provide other appropriate preventive health care to the patient.

In addition, Criteria 11.7, 11.10 and 11.11 fail to acknowledge that immunisation providers are required to upload vaccination details to the Australian Immunisation Register; this should be explicitly required as well as a requirement to notify the patient's usual general practitioner.

Otherwise, this Standard appears to be consistent with the requirements of providing safe and high quality vaccination services, and has caught up with the situation of some pharmacists already providing this service in the absence of a Professional Practice Standard or consistent accredited training.

Standard 13 - Disease state management

Again, as noted in Standards 7 and 10, the AMA supports the role of pharmacists in contributing to patient's overall health in collaboration with medical practitioners.

The criteria and actions under this standard are consistent with good practice, however it should be made explicit that the role of pharmacists in managing chronic diseases is complementary to patient care (usually) led/managed by a general practitioner.

As articulated in 13.7, services should be focused on 'the best interests of the patient', in 'collaboration with other health care professionals', and 'considering the sustainable use of health resources'. Therefore, undertaking services independent of, or that duplicate care provided within, a general practice is not a sensible use of health (or patients') resources.

In a similar vein, it is difficult to identify any chronic disease in which the actions identified under Criterion 13.8 Assessment, Consultation and Reconciliation that would not be most appropriately undertaken by a medical practitioner.

Standard 14 - Medication review

Home medication reviews are a GP referred service and as such Action 14.9.1 should be amended to make it clear that the pharmacist should be working in collaboration with the

patient's usual GP. The action as it stands has the potential to encourage and validate inappropriate reverse referrals.

The AMA suggests that an additional preceding action is included to make this point, and that this be followed with a modified request/initiate action make it clear that this action is for where at risk patients do not have a usual GP.

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