pharmacycouncil
Te Pou Whakamana Kaimatū o Aotearoa

Appendix one

Competence Standards for Aotearoa New Zealand Pharmacist Consultation Key Submission Themes

The purpose of the Health Practitioners Competence Assurance Act (HPCAA) 2003 is to protect the health and safety of the public by providing mechanisms to ensure that health practitioners are competent and fit to practise their profession.

As a responsible authority (RA) charged with administering the HPCAA, Pharmacy Council is responsible for setting standards of clinical competence, cultural competence (including competencies that will enable effective and respectful interaction with Māori) and ethical conduct to be observed by pharmacists.[2]

Competence standards protect the health and safety of the Aotearoa New Zealand (NZ) public by specifying minimum core foundational knowledge, skills and attributes required of health practitioners to register into the following scopes of practice:

a. Intern Pharmacist,
b. Pharmacist, and
c. Pharmacist Prescriber.

Practitioners in all three scopes of practice listed above must meet at a minimum all Competence Standards for the Pharmacy Profession as well as other relevant ethical conduct, and clinical and cultural safety and competence, legislation, and regulations requirements upon registration.

Key changes to the standards implemented after the feedback received

1. The standards and guidance were separated into two documents.

2. The ‘table’ format of presenting the standards was adapted back to the ‘list’ format used in the 2015 Competence Standards.

3. Domain 7: Management and Leadership was split into its:
    - management component, which was integrated into Domain 2: Professionalism in Pharmacy; and it
    - leadership component, which was sequenced as Domain 4

4. The model for breadth and depth of healthcare service (Figure 1) was removed.

5. Performance outcomes were reframed so that:
    - they were part of the guidance document and sequenced at the end of each competency,
    - outcomes for pharmacist prescribers were integrated in the pharmacist prescriber competence standards, rather than the pharmacist competence standards, and
    - outcomes for the ‘advanced pharmacist’ category were expressed as potential examples of advanced pharmacist practice rather than a defined outcome.

Consultation Key Submission Themes

Themes	Brief description	Illustrative examples from public consultation (PC)	Response to feedback
Scope of practice for prescribing	We received a submission requesting prescribing (as an activity) be part of the activities undertaken within the Pharmacist scope of practice (vs. limited to those practising in the Pharmacist Prescriber scope of practice) – e.g., like that of nursing scope which will enable pharmacists to prescribe.	**SH12:** we would like to see the following changes be considered: • a single set of competence standards that encompasses the roles of pharmacists, intern pharmacists and pharmacist prescribers. • …undergraduates are now more competent in a wider range of roles and requirements and undergraduate studies already encompass most of the core competencies required to move into the prescribing role. We would like to see reference to these prescriber capabilities as core competencies to the profession. • recognition that pharmacists have already proven their worth as prescribers during the COVID-19 epidemic, dispensing and supplying oral COVID-19 therapeutics. We believe keeping the competence standards as is would be a regression instead of a progression. Pharmacists have stepped up and evolved, we need the competence standards, legislation, and education to keep up with current needs.	The scope of this project was to review the competence standards within the current legislative regime, and not the scopes of practice. Under Medicines Act 1981 and Medicines Regulations 1984, pharmacists may supply but not prescribe (i.e., writing a prescription) unless they are a pharmacist prescriber (i.e., section 6(d) of the Medicines (Designated Pharmacist Prescribers) Regulations 2013). Therefore, for pharmacists to gain the authority to prescribe legislation needs must be amended. Council would welcome a detailed proposal, and discussion and collaboration with relevant stakeholders. However, development work to update competence standards for pharmacist and pharmacist prescriber will continue as the review of the "Scope of Practice" is outside of the project's scope. This will be considered as a possible separate development programme from 2023. We engaged separately with stakeholders who proposed changes to the scope(s) of practice to discuss more extensively, which included a discussion on the process to propose changes to the scopes.
Scope of practice clarity – professional vs. individual (See figure 1, page 14 of the consultation document)	Differing viewpoints relating to clarity of scope of practice in terms of which competencies are mandatory and which are not. There was mixed feedback on how accurately the model reflects pharmacist practice and the overall utility of the model.	**Request for clarification on when standards apply.** **SH17:** There is inconsistency in the proposed standards, whether all competencies must be met by all pharmacists or those standards that apply to their practice areas... … Are all pharmacists required to meet all competence standards, regardless of their specialised area of practice? Where the scope of practice is specialised, who determines the competencies that apply? When a pharmacist's scope of practice is limited based on specialisation, which competencies apply? If the scope of practice is limited to a specialised practice area, will the PCNZ endorse the APC with a limited scope of practice, and therefore outline the competencies that will apply?	The intent of the figure was to show how foundational competencies set by Council reflect the gazetted scopes of practice, and how foundational competencies also continue to provide basis even if a pharmacist's practice is at an advanced level and/or focused within specific areas of practice. On balance, it seems that the figure provided more confusion than clarification and was therefore removed. Additional text was added to ensure that the same concepts were conveyed.

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	NB: the mandatory and optional model was removed from the 2015 version of the standards.	**SH4:** It is unclear whether domains will be compulsory or optional. Pg 3 point 5 says 'all three scopes… must meet. all competence standards...'. Is it applicable for hospital pharmacists to be able to administer vaccines and/or methadone? **Feedback indicating that the standards are clear.** **SH10:** The standards are very clear. **SH11:** ... acknowledges the robust development process undertaken to develop new Pharmacy Standards and Guidance. We found the table describing the breadth and depth of the pharmacy scope of practice in relation to performance level and the continuum of advanced practice particularly helpful in terms of improving our understanding specialisation within Pharmacy. **Request for revision/removal of the model.** **SH2:** Fig 1 on page 14 is potentially confusing. • It is described as 'Council's competence standards in terms of breadth and depth of healthcare service'. However, would it be more accurate to say that the figure represents '…. breadth and depth of pharmacy practice types? Not only does this more accurate reflect the original use of the figure (as per the reference), but it makes it more relevant for the reader. • We feel there is a risk that the colour coding of the boxes in the diagram suggests that only the Generalist Pharmacist area of practice (orange box) is overseen / regulated by the Pharmacy Council. We assume this is not the intent but suggest that consideration is given to revising the diagram or the labelling as it is important for the figure to be self-explanatory as many people will not read the associated commentary in depth. • While Bullet points 10,11 and 12 aim to further expand on Fig 1, the information might be more easily understood in a 'How to use' section. • Bullet point 11 includes Primary care practice as being 'a narrower breadth of health service' which we would disagree with. Pharmacists working in general practice need to be generalists and more likely to be working at or towards an advanced level. **SH10:** We disagree that primary care and general practice provide a "narrower breadth of health service" than community pharmacy. The roles are very different but certainly not narrower. Perhaps the terminology "narrow "could be reviewed. For instance, a clinical pharmacist working in secondary care may provide a wide breadth of health services (dispensing, ward rounds, teaching, policy), as does a clinical pharmacist working in primary care or general practice, who is usually by	

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		virtue of the nature of the primary care role a specialist generalist. (medication review, physical assessment, chronic care and acute care clinics including virtual consultations, triage, prescribing, vaccination, policy, teaching, audit, research)These aspects might be considered as alternative 'branches' of pharmacy practice, and we consider there to be 3 main branches of pharmacy practice , but are not necessarily more narrow in their breadth; although there are some practitioners amongst those who may work in a very specialised ,and hence narrow, area such as oncology, haematology, transplants etc. but these roles are not usually applicable to the majority of pharmacists working in primary care and general practice at this stage	
Performance outcomes specification	Differing viewpoints on the value of the performance outcomes (e.g., Intern, Pharmacist) and their details. Some feedback was received that the performance outcomes for intern pharmacists, as currently written, are not feasible. N.B. The Pharmacist Prescriber Standards Expert Group (PS-WAG) suggests for the Pharmacist Prescriber column be removed from the performance outcomes. N.B. The intern pharmacist proficiency outcomes are intended to apply to an applicant who has recently graduated and just entered the intern pharmacist scope	**Request for proficiency outcomes be removed or modified.** **SH2:** As discussed outside of this feedback process, there is recognition that further work needs to be done to develop a document that outlines expected levels of practice beyond initial registration. We therefore understand why a 'Continuum of proficiency outcomes and development' has been included, but as it is currently written it is piecemeal, and a lot more detail is required for it to be helpful. In some instances, the difference between the different levels is debatable. For instance, with respect to 3.3., the wording at the General level seems almost a step down in expectation from the Intern level. • Intern - Recognises the impact of conflict in the workplace and demonstrates skills and a "blame-free" and positive approach to resolving conflict. • General - Can describe a range of possible approaches/ strategies that are effective for resolving conflict in the workplace. We would see that 'demonstrates' is a stronger action that 'can describe'. In short, we have not reviewed the Continuum in detail as we feel it needs much more work and as it stands should not be included in the Competence standards. **SH14:** We seek clarity around conflicting language across the documentation alongside what appears to be a significant shift in focus… the hurdle previously to becoming a fully registered pharmacist was successful achievement at the assessment centre. As written in the draft documents, it now appears that the last hurdle is for students exiting BPharm programmes [i.e., since it is written across multiple points that they must meet at a minimum competence standards]. Put differently, for our graduates prior to 2023, we were building graduates towards the competence standards, then they enter the intern programme, and, at the end of that process, they then were deemed to have met the baseline 'minimum' competence standards. Now it seems the hurdle has shifted to our BPharm graduates needing to meet the minimum competency requirements at the point of	CS-WAG viewed the performance standards as fair, reasonable, and clear. In the absence of professional practice standards, they decided that advanced performance outcomes should be retained. However, they acknowledged the need to change the format so that the proficiency continuum is positioned within the commentary section – which should help minimise the potential for confusion. Additional explanation was added to clarify that the intern pharmacist performance outcomes apply at the transition point from pharmacy graduate to intern pharmacist, the pharmacist performance outcomes apply at the transition point from intern pharmacist to pharmacist.

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		graduation and prior to registration into the Intern Scope of Practice and entry into the Evolve programme. **SH13:** Including variations of expectation in levels of practice is not helpful as part of the standards. These should either be deleted (and addressed as part of Professional Practice Standards – to be developed) or moved to the commentary (which is separate from the standards). Including them on the same page as the foundational level standards/competencies is confusing and distracts from the intention of the standards. It also requires a lot of words on one page printed in a very small font which makes it difficult to read and make sense of.	
Te Tiriti & Cultural Safety	There was mixed feedback on whether Te Tiriti & cultural safety had been appropriately incorporated in both the development process and the content of the standards and guidance.	**Critical of the extent of integration of Te Tiriti & cultural safety** **SH3:** excessive emphasis on Treaty of Waitangi… …far too much emphasis - 1.2 should be part of 2.3 - encompasses all cultures. **SH6:** Ethnicity only has a place in healthcare when genetics have a place in determining the best course of treatment (e.g., Han Chinese may not respond to some medicines requiring activation by CYP enzymes, necessitating different choice of treatment). It has no place in policy documents. All New Zealanders deserve fair and equal access to quality evidence-based healthcare. **SH8:** The Treaty document has 3 clauses granting all New Zealanders the same rights in property, in law, and under Government. All New Zealanders. And as such has no relevance to competence standards for pharmacists. Patients are treated as individuals, and cultural competence demands that as providers we must make every effort to understand the needs and ideas of each individual, by listening to their words and reading their gestures. Assuming that individuals from any ethnic group are like any other members of the same ethnic group is potentially misleading. Seeking to understand each individual regardless of ethnicity will benefit that individual far more. Accordingly, these standards would be vastly more useful if all references to the treaty were removed. **Supportive of the extent of integration of Te Tiriti & cultural safety** **SH10:** We agree with the process for the development of the Competence Standards and Guidance document. This has been a robust process. We were pleased to see the establishment of, and interwoven input to the standards from the Te Tiriti Advisory Group. We support the establishment of an Expert Working and Advisory Group… …We agree to the best of our knowledge and experience that the standards and guidance appropriately give effect to Te Tiriti o Waitangi but would defer to the Te Tiriti Advisory Group re this.	CS-WAG viewed the standards and guidance to be appropriate, practical, tangible and in fact, one of the best of all RAs and general standards. Council will be working closely with the professional associations (and the profession generally) to assist practitioners in applying the standards to aspects of day-to-day practice.

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		SH11: The standards in Domain 1 are comprehensive and effectively recognise Te Tiriti o Waitangi. We suggest that inclusion of the points below would enhance the new standard, provide a deeper understanding of Te Ao Māori, and facilitate a more active approach to working toward better understanding of the barriers facing Māori, including: • Understanding of the role of structural racism and colonisation and ongoing impacts on Māori • Socioeconomic deprivation • Restricted access to the determinants of health • Developing authentic relationships with Māori organisations and health providers. **SH13:** I note that that these reflect the competencies suggested in Heather Came et al's article in NZMJ. I would suggest that the Council produce some more guidance than just the commentary about the background and what is expected of entry level pharmacist for this domain. I commend the intentional integration of the principles of Te Tiriti o Waitangi. I recommend that the commentary clearly articulates how these competencies are relevant and applicable to professional pharmacy practice and provide guidance about how these can be integrated into day to day practice and measured.	
Enhanced guidance on application of the standards	Feedback requested that additional practical examples be provided to guide the application of standards to practice	**SH6:** I think the competence standards are clear, but could be explained better with example scenarios. **SH16:** Tables provide a large volume of information that is difficult to access, and no examples are provided to assist with interpretation/translation of information. Recommend providing Case studies in the guidance this would support 'translation' of the standards but particularly for the behaviours. Perhaps there is an opportunity to provide this as part of the implementation process for the updated document.	CS-WAG viewed the current level of explanation and exemplars as appropriate in the absence of more substantial professional practice standards. CS-WAG acknowledged that case examples should be developed and led by professional associations.
Terminology	Feedback questioned the use of various terms	**SH10:** "Medicine management" terminology - We are disappointed this term is still being used. We appreciate the definitions that have been added and rational given to clarify this, however we note these references are 18 and 21 years old respectively and date from before many pharmacists were actively undertaking formal medication reviews and making recommendations (or prescribing). Although there is a definition it is a misused term. Pharmacists involved in the time that this term was initially used in the competencies would recall that it was a catch phrase and tried to cover all things to be inclusive. We believe it is time to make a distinction and use a new or additional definition. In roles where there is a clinical decision making, responsibility and accountability the pharmacist is not "managing" but is a clinician working with the person. If this term is to be continued to be used it would be appreciated if it could be ensured to be defined the way you intend it	CS-WAG viewed the term "medicine management" as appropriate particularly given the description of the term as a holistic cycle that encompasses all steps of medicine use and reference to Stowasser et al., (2004). The term "consumer" was replaced with "person" and "people" preferred. A definition was provided to highlight that these words are used interchangeably and, where appropriate, is inclusive of whānau.

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		"Consumer": We understand this term "consumer" is acceptable to consumer groups instead of person/ whanau. As it is not a term we are familiar with in respect to person centred healthcare, we would like assurance if this is acceptable to whanau. **SH11:** We suggest that the Domains replace Behaviour with Performance to reflect the intent. 4 The competencies relate to expected expertise, and expected performance relates to how the actions are to be achieved.	CS-WAG viewed additional value for the use of "performance" over "behaviour", so the incumbent term was retained.