



SASKATCHEWAN
COLLEGE OF
PHARMACISTS

Saskatchewan College of Pharmacists

Quality Assurance Framework

For

Enhanced Authority for the Pharmacist

To

Prescribe Drugs

In

Collaborative Practice Environments

December 2011

In response to consultations with stakeholders, the Council of the SCP incorporated several measures designed in whole or in part to assure the quality of pharmacists prescribing drugs. They are:

- 1) We have implemented interdependent (not dependant or independent) prescriptive authority in collaborative practice environments. For pharmacists this means that other team members rely upon them to make the best possible drug use management decisions, including prescribing drugs, in the best interests of the patient. The pharmacist works with other team members who rely upon their extensive drug therapy knowledge and skills.
- 2) The term “collaborative practice environment” is defined in the SCP bylaws. It exists when a practitioner (e.g. physician, dentist, Registered Nurse (Nurse Practitioner), optometrist, midwife) can reasonably rely upon pharmacists’ basic skills to prescribe in best interests of patient, and to communicate such decisions to the practitioner (either to prescribe a drug, and if not, a referral if justified). The environment is presumed to exist when pharmacists prescribe according to the requirements of the bylaws. They specify some limits and expect pharmacists to prescribe only when having met the competency, assessment, documentation, communication and transparency requirements. The environment does NOT exist when practitioner communicates otherwise.
- 3) Prescribing is competency based meaning that pharmacists are asked to optimize the use of their current competencies.
- 4) SCP has not expanding the scope of practice of pharmacists as this authority to prescribe within the pharmacist’s scope of practice was granted in 2003. Therefore, we are not expecting pharmacists to be trained to practice in another profession’s scope such as medical diagnosis. We expect pharmacists to use existing assessment skills in their decision making.
- 5) SCP has not created new standards of practice. Current standards remain in force, while some of these are being emphasized. For example, our standards expect pharmacists to play a role in monitoring, follow-up and continuity of care. When prescribing, pharmacists are expected to follow the same standard as other prescribers by taking responsibility for their decisions and by monitoring the patient’s response and following up with the patient as needed to ensure continuity of care.
- 6) Prescribing by pharmacists has been designed to be compatible with current health system. It allows pharmacists to prescribe within conventional settings such as primary, secondary, tertiary, acute, long-term and home care, and within current environments using the tools and resources at their disposal. We do not expect pharmacists to modify their practice setting or environment, such as co-locating with physicians as a pre-requisite.
- 7) The legislation is mostly enabling in nature, meaning that it mostly describes what pharmacists are allowed to do. In some cases it is enabling within limits. Some of these limits are maximum prescription quantities and days’ supply, prescribing within one’s competencies and advanced or Level II prescribing according to collaborative practice agreements.

- 8) Pharmacists may prescribe drugs within a self-regulating professional accountability framework consisting of:
 - 1) Adherence to codes of ethics;
 - 2) Compliance with standards of practice;
 - 3) Maintenance of continuing competency through continuing education and continuing professional development; and complaints management of substandard care, competency or conduct.
- 9) Another accountability measure is transparency through documenting their decisions in their records and in the Pharmaceutical Information Program, and communicating their decisions to other practitioners within the collaborative practice environment.
- 10) Pharmacists may only prescribe for minor ailments according to guidelines approved by Council. The approved guidelines have been prepared by the Saskatchewan Drug Information Service based upon the best available evidence, pharmacist focus groups and expert review. The drugs and conditions selected were initially based upon where drugs for medical conditions have been switched or are candidates for switching from prescription to non-prescription status in other countries.
- 11) Level I training is mandatory for all pharmacists who engage in prescribing. Minor ailments prescribing are considered Level I prescribing, and separate training is also mandatory for prescribing. SCP intends to integrate this training, and has agreed in principle that it becomes a condition of licensure. The training is focused upon the legislative, policy and practice requirements and process to achieve consistency.

With the introduction of minor ailments prescribing, the Interdisciplinary Advisory Committee on Prescriptive Authority has agreed that SCP should plan and implement an evaluation framework to measure the effectiveness of this prescribing. We will plan to implement the following measures as part of the foregoing quality assurance framework:

- 1) SCP will ask researchers at the University of Saskatchewan, principally faculty at the College of Pharmacy and Nutrition with a pharmacy practice research interest to study the effectiveness of minor ailments prescribing by pharmacists. Research may be qualitative or quantitative and study patient access to meet their needs, patient outcomes, safety, and patient, pharmacist and physician satisfaction. Specifically we will ask that they consider adopting or adapting a research model recently conducted in Scotland and piloted in Australia (see attached article);
- 2) Practitioner groups will be consulted where the research affects or involves practitioners;
- 3) SDIS will be asked to continuously review and update the guidelines and collaborate with the Continuing Professional Development for Pharmacists Unit and the SCP in incorporating the changes within the training programs and updating pharmacists;

- 4) SDIS will be asked to monitor developments in other countries with drug switches to non-prescription status and recommend and develop new evidence based guidelines according to these trends for expert review and approval by SCP Council;
- 5) SCP Field Officers will gather data as part of their routine pharmacy and professional practice evaluations. Our target is to visit each pharmacy at least once every three years. As part of these visits, they will examine Pharmacist Assessment Records and will extract data for reporting to SCP relating to the effectiveness of pharmacist prescribing in general, and specifically targeted towards minor ailments prescribing. We will consult with interested U of S researchers on the proper protocols and research questions and methodology;
- 6) SCP will collaborate with the Saskatchewan Prescription Drug Plan and the Health Information Solutions Center (now eHealth Saskatchewan) to access administrative, claims capture and adjudication, and patient profile data to determine trends and compliance with standards. Our Field Officers will need some of this data to target their review of pharmacy documents and collection of data; and,
- 7) SCP Council will continue the Interdisciplinary Advisory Committee to advise them on issues arising from this framework.
- 8) Where appropriate, research will be reported in the professional literature, as well as in the SCP annual report.

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Developing and validating a tool for assessment of pharmacist prescribers' consultations

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Objective. To develop and validate an assessment tool, based on the 'Royal College of General Practitioners' (RCGP) Video Assessment Tool', for assessment of pharmacist prescribers' consultation skills.

Methods. Competency areas of the RCGP tool were left unchanged but performance criteria for each were modified to reflect pharmacist prescribing. Each criterion and the overall consultation were rated from 1 (poor) to 5 (excellent).

A purposive sample of 10 experienced prescribing pharmacists was selected. Each pharmacist identified, recruited and consented two patients. Video recordings of consultations were assessed independently by two randomly assigned GPs, experienced in the use of the RCGP tool, using the newly developed scale. Inter-rater reliability was assessed. Construct validity was assessed by comparing the assessor score with a patient satisfaction score. Spearman's rho was used to test the correlation between the two scores.

Results. The RCGP tool was modified to give the 'Pharmacist Consultation Assessment Tool' (PharmaCAT). The median overall PharmaCAT consultation rating was 3. There was good agreement between the two assessors for total scores (intraclass correlation coefficient = 0.694). Fourteen (78%) patient satisfaction questionnaires were returned; most (n = 13, 93%) agreed/strongly agreed that they were entirely satisfied with the consultation. Correlations between average total scores on PharmaCAT and the patient satisfaction questionnaire were weak (Spearman's rho = 0.142 and 0.242 for both assessors).

Conclusions. The PharmaCAT has been tested in the pharmacist prescriber setting. The tool had discriminatory power across different domains and inter-rater reliability. The PharmaCAT has potential to be used as a formative and/or summative assessment tool.

Keywords. Communication skills, consultation, pharmacy, prescribing.

The article is available at:

<http://fampra.oxfordjournals.org/content/27/5/520.full.pdf+html>