Points from the PSA prescribing survey responses by students (111)

- The majority of students believe that patients would accept the role of pharmacists as prescribers with 60% unhappy with the current pharmacists prescribing role being limited to S2 and S3 medicines. 23% neither disagree or agree and 37% feel strongly about the limited role i.e. not happy.
- 35% of students believe patients would have safer access to medicines if pharmacists were prescribers (30% neither agree or disagree)
- 46% strongly agree that expanding pharmacist prescribing would ease the burden on our healthcare system (36% agree)
- The majority agree that pharmacists have the necessary training to be able to prescribe medicines
- There were split views on pharmacists having the necessary patient assessment and diagnostic skills to be prescribers
- Majority believe that pharmacists should be able to prescribe collaboratively of medical practitioners through an agreed patient-specific management plan (~95%)
    - Majority agree that pharmacists should be able to prescribe for a 30 day emergency supply, rather than a 3-day supply currently
- Over 60% of students believe that inadequate training in diagnosis of disease is a barrier to pharmacists prescribing
    - Responders agree that pharmacists have adequate training in patient assessment
    - There are split views of the need for separation between dispensing and prescribing
        - Somewhat agree to separate dispensing and prescribing
    - Barrier is that pharmacists lack time
    - Pharmacists have inadequate facilities to be able to prescribe within the community pharmacy setting (~50%)
- In reference to collaborative prescribing:
    - The following chronic conditions would be suitable: antibiotics, diabetes cardiovascular disease, asthma, pain
    - The following chronic conditions have split views: anticoagulants
- Students have a split view on pharmacists needing further training in clinical pharmacology to take on collaborative prescribing
    - ~30% disagree and ~40% agree. The reason for such responses could be that students did not understand what was meant by clinical pharmacology in regards to further training as pharmacists. Pharmacists already have 4 years of training them about pharmacology and medicines use which is used in both the community pharmacy and hospital setting)
    - Pharmacists have appropriate training on: pharmacodynamics and PK, adverse drug reactions and interactions,

- Pharmacists need further training on: pathology of conditions that would prescribed for, patient consultation and decision making, patient assessment, diagnosis
- Split views on further training in areas such as: evidence-based practice (most believe pharmacists have the adequate training already), communication skills, and selection of appropriate medications

- Separation of dispensing and prescribing functions and any issues regarding the medical and pharmacy groups need to be resolved prior to the implementation of any pharmacist prescribing roles (over 50% agree)

		Prescribing under a structured prescribing arrangement	**Prescribing under supervision**	**Autonomous prescribing**
PUBLIC NEED				
1	How would these models of prescribing by pharmacists fulfil a public need?	Pharmacists would be able to bridge the gap in providing medicine access to patients that may have run out of a script or are in need of a change in dose of medications which are able to be managed by the pharmacists clinical skills. This would reduce the need in having patients book in a doctors appointment for chronic and typically unchanging conditions. Collaborative communication between the pharmacist and medical practitioner will ensure adequate and appropriate care is given.		Pharmacists will be able to prescribe for conditions such as an uncomplicated UTI, the oral contraceptive, travel vaccination profiles, dose or medication changes due to supplier stock issues and potentially anticoagulants e.g. in the hospital setting if it has been missing from drugs charted for an inpatient given the hospital's pre-established protocol. This would allows for timely and appropriate medication access whilst also allowing for e.g. medical practitioners to focus on

		The ability for pharmacist to prescribe generally lessens the health care burden and also allows for timely access to medications that can be used with patients flagged as low risk. The prescriber structure in this case, would be the recognition of when it is appropriate to refer the patient to a specialised level of care rather than a condition which is considered "common"such as a UTI.		more complicated cases that may require more time.
EVIDENCE (published or unpublished)				
2	What is the evidence that these models of prescribing by pharmacists would be a safe and effective way of improving access to medicines for the community?	Study by Lisa Neissen and pharmacists prescribing internationally such as providence's of Canada, parts of the UK has proven effective and beneficial to patients.		Pharmacists do prescribe under this model internationally. As an example, some registered UK pharmacist prescribers are autonomous prescribers. The community has found this to be of great benefit with these pharmacist able to provide e.g. a full portfolio of travel vaccinations. Considering the fact that pharmacists are now also able to vaccinate in Australia, autonomous prescribing in this case, would allow pharmacists to

				provide a full and comprehensive service to their community.
3	What is the evidence that these models of prescribing by pharmacists support the *Quality Use of Medicines (QUM)*, i.e. judicious, safe, appropriate and efficacious use? (For example, by minimising overuse of medicines, reducing adverse events, improving health outcomes and/or other elements outlined in QUM)			Stock availability issues in the UK have been addressed through pharmacists autonomously prescribing alternative medications for their patients within the individual pharmacist's confidence of their practice and according to pre-establish protocol and resources. This practice has not seen outstanding harm to patients.
4	Are there any gaps in the evidence for pharmacist prescribing under these models? If so, how could this evidence be obtained?			The evidences missing in this field is patient perspective and support. The system will only be a benefit, if the patients feel confidence in the ability of the pharmacist to practice autonomous prescribing.
EDUCATION AND TRAINING				

5	What education requirements (if any) would pharmacists with general registration need to complete to competently prescribe under each model? (i.e. postgraduate education)	Pharmacists should be required to undertake prescribing training alongside GP's. This will ensure this model is effective so that both healthcare practitioners are aware of each others roles, scopes and limitations to allow for effective and safe inter-collaborative prescribing.		Further tertiary training either through a university masters degree or through an external training program such as the HMR training through the AACP. This allows for confirmation of knowledge before allowing autonomous prescribing.
6	Are current undergraduate program providers addressing the competencies to prescribe under each model? If not, what are the gaps and how can they be addressed?	Undergraduate program providers already address the competencies of prescribing under each model. Students are able to identify medicine related issues, when to prompt medication initiation based off evidence based guidelines. It would however, also be necessary to enhance and cement the theory of prescribing via practical sessions with patients and other health care providers.		For uncomplicated conditions, the undergraduate program does address the competences of prescribing, again based off provided evidence based guidelines. However, the practice of diagnosis does need to be taught to a higher degree in order for students to graduate ready to be autonomous prescribers. This is why further study for autonomous prescriber qualification is recommended.

7	Before being authorised to prescribe under each model, would a pharmacist need to accumulate a minimum period of supervised practice under the supervision of an authorised prescriber (e.g. during the internship, before gaining general registration or after gaining general registration)?	Yes, should align like nurse practitioners where they have 5 years of workplace experience then can apply for masters and are entitled to prescribing abilities. Pharmacists should adopt a similar model. Experience would enhance effective prescribing and safe practise.
8	Before prescribing under each model, would a pharmacist need to have achieved a minimum period of practice experience as a pharmacist with general registration? If so, for what period?	Yes. Pharmacists should complete registration and be practising for an agreed amount of years (eg. 5 years), then are entitled to return to university/education provider, undertake supervised practise then have the ability to prescribe.
9	Would pharmacists prescribing under each model need to meet different annual CPD requirements to pharmacists who do not prescribe?	Yes, different CPD requirements will reflect different scopes of practise, knowledge requirements and capabilities. Prescribing pharmacists should complete general CPD and then additional CPD focused on prescribing under the proposed model.
REGULATION		

10	Would these models of prescribing by pharmacists require additional regulation by the Pharmacy Board or could it be adequately governed through relevant jurisdictional policy or legislation?			An endorsement for scheduled medicines in accordance with Section 94 of the National Law would be required for pharmacists to prescribe under this model.
11	What are the risks associated with each model of pharmacist prescribing and how could they be managed?	With all models, the idea of pharmacists prescribing may cause some unease among some other healthcare colleagues. Given a robust proposed qualification system, education of the community as to changes in the recognised scope of practice and time, this issue can be combated.		
OTHER				
12	What factors would contribute to sustaining each model of pharmacist prescribing if introduced?	Education to already registered pharmacists on the risks and benefits of prescribing and encouragement to undertake further study. Re-accreditation of the Pharmacy schools of Australia to include adequate and comprehensive pharmacist prescribing courses would be helpful.		
13	Do you have any additional comments about these models of prescribing by pharmacists?			