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Mr Michael Guthrie
Director
Accreditation and Quality Assurance
Australian Dental Council

By email: projects@hpacf.org.au

Dear Michael

Re: Health Professions Accreditation Collaborative Forum Safe Prescribing Project.

Thank you for offering the Australian Dental Association (ADA) with the opportunity to provide feedback on the Framework for the safe use of medicines in accredited health professions programs of study, The ADA supports the principle outlined in the discussion paper that 'all health practitioners need a foundational knowledge in quality use of medicines regardless of whether or not they also have prescribing rights and it is not intended that the Framework be used to advocate for any profession to be endorsed to prescribe. The necessary education and training that is required in order to safely and effectively prescribe is beyond the content of this framework. On that basis, the ADA provides the following responses to the questions posed in the discussion paper.

1. Do you support the proposal for a common framework of key principles, criteria and learning outcomes for safe and effective use of medicines by beginning practitioners in a regulated health profession?

The ADA supports the need for a common framework in principle noting that this framework is designed only to provide all registered health practitioners with a minimum base of knowledge in the quality use of medicines but by itself does not provide the minimum competence required for prescribing.

Given the requirement for inter-professional practice as part of the criteria, which can be difficult to coordinate between courses where there is none or limited overlap in subject delivery, a 'grace period' may be required as part of the rolling out process of accreditation standards to overcome this practical challenge and ensure that other important aspects of the curriculum do not suffer. A pre-defined review period may also be particularly pertinent given the possible impact of current initiatives such as My Health Record & a move toward electronic prescriptions on the necessary prescribing and interdisciplinary management skills and attributes of graduates.

2. Referring to the principles set out in section 3.1, are there additional principles that should be included?

There seems to be some confusion in the language used in section 3.1. The principles are intended to apply to all health practitioners to set a minimum standard of understanding including those who do not have the necessary education and training to prescribe, however, the principles as currently worded suggest that they particularly apply to prescribers. Further detail should be provided to provide clear separation between the expectation of prescribers and non-prescribers role in the quality use of medicines.

3. Do the proposed learning outcomes adequately connect Quality Use of Medicines framework and the NPS National Prescribing Competencies with extant individual professional competency statements?

While the proposed learning outcomes appear feasible, it is not clear how these outcomes could be achieved without significant increase in the level of education provided in undergraduate health programs of study. Any expectation of health practitioners to be involved in providing explanations to patients, clients and families if they do not have the full knowledge and training may result in misinformation being provided to such audiences. The discussion paper acknowledges, there is a correlation between medication errors when more practitioners are engaged in the care of patients with highly complex health care needs- there is an increased risk of such occurrences if non-prescribers interfere in the administration of medications or decision making of patients. The primary driving factor must be the best outcomes for the individual patient as set out in point 2.

Similarly, 3.3.4 is of concern. The evidence for effective use needs to be from carefully controlled clinical studies and not individual patient experiences.

It is imperative that there is open communication amongst all treating health practitioners to ensure optimal prescription and management of medicines for all individual patients, however, the responsibility for the coordination of care, with regard to prescribing and management of patient medicines, should lie with the practitioner who prescribes the medication.

4. How could these criteria and learning outcome statements be implemented within your area or discipline?

As dentists are already prescribers it is likely that most of the criteria will already be embedded in the education and training of these practitioners. Coordinators of dental programs should map existing learning outcomes to ensure that all components are incorporated.

For those dental practitioners who are not prescribers there will need to be consideration as to how these outcomes can be incorporated into existing programs of study and how the criteria and learning outcomes statements will apply, as there will be a variation in clinical knowledge and competency requirements depending on an individual practitioner's scope of practice. These variations will need to be taken into consideration throughout the accreditation process of each specific course as it relates to the range of health services provided by practitioners within each regulated health profession.

5. If these principles, criteria and learning outcome statements were embedded what effect on patient outcomes is likely?

As long as existing collaborative care arrangements are maintained then the ADA believes that it could lead to a reduced rate of medication-related adverse outcomes, although this may not be reflected specifically in dentistry, given the low base rate of adverse outcome reporting that currently exists.

6. Does the framework under Section 3 give sufficient emphasis to preparation for inter-professional practice as the foundation for safe use of medicine? If not should inter-professional practice be given greater emphasis in general or specifically related to preparation for safe use of medicine?

Yes, this is appropriate in the proposal and is supplementary to an existing broad requirement to "understand the importance of intra and inter-professional approaches to health care."

However, if the intent is to broaden who can prescribe medication then the overwhelming priority must be patient safety and only fully and comprehensively trained persons should be allowed to prescribe.

Furthermore, the ADA recommends reconsideration of the definition within the framework appendix of terms may be advisable. The current definition indicates that:

"Inter-professional education occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes."

It may be advisable to amend this definition to:

"when two or more professional learn about, from and/or with each other to enable effective collaboration and improve health outcomes" in the first application of these criteria.

7. How should the success of any accreditation standards, principles and/or learning outcomes in this area be evaluated?

It is worth evaluating the success of these accreditation standards in achieving the purported goal of patient outcome improvement. It may be important also to review whether students find the experience to be authentic and useful given that some mandated inter-professional learning experiences are sometimes perceived to be tokenistic. ADA believes that success would best be gauged using small trial group evaluations.

8. Are there any further comments you would like to make?

It is important to recognise that there are five different divisions of dental practitioners and only dentists have the full scope of practice including prescribing rights. The remaining four practitioner groups receive little education in the medical sciences and no training in pathology and pharmacology which are foundational knowledge for prescribers.

Incorporating any components of this framework should not be used as justification for access to prescribing rights. Prescribing requires an in-depth knowledge of the clinical sciences including biochemistry, physiology and pharmacology.

If the Australian Dental Council (the accreditation body for the registered dental practitioners) perceives that the inclusion of these criteria will lead to a marked change in the accreditation standards, such as integration

of the criteria throughout existing domains, leading to effects on the existing criteria, further opportunities for comment from key stakeholders on the overall accreditation standards in their revised form should be forthcoming.

As a further comment, we would like to suggest an amendment to the appendix of terms in relation to risks and benefits so that it reads: - risks and benefits, '*particularly the impact of adverse reactions and drug interactions'.*

The ADA would be very happy to expand further on the comments provided if necessary. Please do not hesitate to contact Ms Eithne Irving, Deputy CEO on 02 8815 3332 or eithne.irving@ada.org.au if required.

Yours sincerely

Dr Carmelo Bonanno
Federal President