GUIDELINES FOR THE IMPLEMENTATION OF COLLABORATIVE PRESCRIBING SERVICES (JANUARY 2026)

MINISTRY OF HEALTH
SINGAPORE

Version 3
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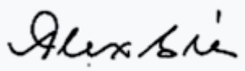
FOREWORD

I am pleased to introduce the new edition of the MOH Collaborative Prescribing Guidelines. The new edition marks a new milestone with the introduction of Entrustable Professional Activities ("EPAs") in collaborative prescribing for adults and paediatric patients. EPAs will serve as the basis for a competency-based approach to the training and assessment of Collaborative Prescribing Practitioners ("CPPs") as well as the foundation for future modes of prescribing by other professions as we transform our healthcare workforce to better care for an ageing population.

This new edition also includes updates to the maintenance of competency ("MOC") requirements, which have been developed based on feedback from CPPs. These updates are timely as the number of CPPs has reached more than 350 since collaborative prescribing was introduced in 2018. CPPs are currently serving patients in the hospitals, polyclinics, and in the community including, our homes. The updated MOC requirements will ensure CPPs continue to provide safe and effective prescribing services.

I would like to express my appreciation to the members of the Collaborative Prescribing Standing Committee and the Competency Standards Subcommittee for updating the Collaborative Prescribing Guidelines. I am confident that the updated guidelines will further strengthen the practice of collaborative prescribing as we continue to transform healthcare delivery in Singapore. Thank you.



Prof Alex Sia
Chief Executive Officer, KK Women's and Children's Hospital
Chairperson of Collaborative Prescribing Standing Committee

CONTENTS

Entrustable Professional Activities ("EPAs")
for Adult and Paediatric Collaborative Prescribing

This section sets out the EPAs, which are units of professional practice that can be entrusted to a Collaborative Prescribing Practitioner once they have demonstrated the necessary competence at a specified supervision level.

Level	Descriptors	
Level 1	**Permission to be present, not to enact the EPA** The learner requires complete hands on guidance / did not do the activity / was not given the opportunity to do the activity.	
Level 2	**Direct supervision. Pro-active supervision.** The learner is able to carry out the full activity by himself or herself but requires constant guidance / direction. The supervisor is in the room watching and can intervene or take over at any time deemed necessary.	
	a.	EPA conducted as a co-activity with supervisor
	b.	EPA conducted alone, with supervisor in the room; ready to step in as needed
Level 3	**Indirect supervision. Supervisor is available for reactive/on-demand supervision.** The learner demonstrates independence in carrying out the full activity by himself or herself, but requires intermittent guidance / direction.	
	a.	All findings / decisions double checked
	b.	Key findings / decisions double checked
	c.	Findings / decisions discussed on learner's request
Level 4	**Limited supervision.** The learner demonstrates ability to carry out the full activity by himself or herself with no supervisor available. The learner will report post hoc on the same or next day. This stage will gradually extend into fully mature and unsupervised practice, but as long as the learner is in training, he or she will carry out the activity under 'clinical oversight' or 'backstage supervision'.	
	a.	Supervisor is available on call to come and provide supervision
	b.	Supervisor is not available but may provide feedback and monitoring in hindsight
Level 5	**Permission to supervise others in practice of this EPA.**	

EPAs for Adult Collaborative Prescribing Practitioners ("CPPs")

	EPA titles	EPA Category	Entrustment level
1	Perform an initial assessment and formulate management plans	Core	3b
2	Manage follow-up care for a patient	Core	3c
3	Recognize and manage or escalate patients requiring immediate or further clinical attention	Core	3a
4	Manage care transitions between healthcare professionals within and between healthcare settings	Core	3b
5	Collaborate with patients, families and community to improve health through disease prevention and health promotion	Core	3b
6	Plan, perform procedure(s) and evaluate outcome of the procedure(s)	Additional	2a
7	Manage care of patients with chronic, advanced or end-stage diseases across care settings	Additional	3b
8	Manage care of perioperative patients	Additional	3b
9	Manage patients with chronic pain	Additional	3b

Title	EPA 1: Perform an initial assessment and formulate management plans
Specifications and limitations	This EPA includes all key activities which a Collaborative Prescribing Practitioner (CPP) needs to perform whenever a patient is admitted, transferred or before any care procedure for forward care planning. The specific functions which define this EPA include: 1) Gather information through thorough history taking with physical examination if necessary 2) Order or propose investigations if required 3) Interpret investigation results if required 4) Develop or confirm main and differential diagnoses based on findings 5) Adapt treatment based on clinical reasoning and evidence-based practice tailored to individuals and/ or based on existing protocols/ guidelines 6) Develop and provide relevant pharmacological and non-pharmacological treatment options in partnership with patient 7) Explain and ensure that patient/ caregiver understand the management plans 8) Recognize when to seek guidance and escalate care to seniors and/ or relevant members of the healthcare team and follow up accordingly 9) Initiate appropriate referrals to interdisciplinary teams based on findings 10) Document clinical encounter in the patient record
	Limitations: This EPA is applicable to the scope of practice defined in the Collaborative Practice Agreement or its equivalent
Sub-competencies relevant to this EPA	Full description of sub-competencies is found at end of this section

Sub-competency category	Applicable sub-competencies
Patient care ("PC")	PC1, PC2, PC3
Medical knowledge ("MK")	MK1, MK2
System-Based Practice ("SBP")	SBP1
Practice-Based Learning and Improvement ("PBLI")	PBLI1
Professionalism ("P")	P1, P2, P3
Interpersonal and Communication Skills ("ICS")	ICS1, ICS2, ICS3

Required knowledge, skills, attitudes and experience to enable summative entrustment	**Knowledge**	• Anatomy and physiology • Advanced pathophysiology • Advanced pharmacology • Psychosocial factors that impact health outcomes • Differential diagnoses, risks and complications • Disease specific investigations (including indication), treatments, interventions and complications • Pharmacokinetics and pharmacodynamics • Knowledge of pharmacology and drug interaction • Protocols, safe monitoring and side effects, including life-threatening side effects • Applied therapeutics • Red flags • Referral processes • Available resources
	Skills	• Advanced comprehensive health assessment (mental, physical and social) and re-assessment • Interpretation, analyzation and synthetization of assessment and diagnostic investigations findings (including distinguish between normal variation and abnormal findings) • Assessment and management of side effects • Management of discontinuation and recommendation of pharmacological treatment modality • Clinical reasoning and decision-making skills • Effective interpersonal and communication skills • Clinical documentation skills • Organization skills
	Attitude	• Respectful towards patients, families and other healthcare team • Make clinical decision/s in accordance to professional standards, scope of practice and level of competence • Uphold professional attributes during patient care • Reflect on practice • Recognize own limitations and seek assistance when necessary
	Experience	Entrusted with relevant small nested EPAs: • Obtain history and perform physical examination (if necessary) • Formulate and prioritize differential diagnoses • Recommend and interpret common diagnostic and screening tests • Provide a handover in transition of care • Formulate, communicate and implement management plans • Present and document a patient encounter in the patient record

Source of information to support summative entrustment decision

Assessment tools	Number to be completed satisfactorily	Assessors
MiniCEX + Entrustment Based-Discussion (EBD)	At least 1	Clinical Supervisor, CPP Senior
Case Logs	At least 1	Clinical Supervisor, CPP Senior

Entrustment / Supervision level expected at which stage of training. (At the end of supervised practice)

Level	Descriptors		
Level 3	**Indirect supervision. Supervisor is available for reactive/on-demand supervision.** The learner demonstrates independence in carrying out the full activity by himself or herself, but requires intermittent guidance / direction.		
	a.	All findings / decisions double checked	
	b.	Key findings / decisions double checked	**X**
	c.	Findings / decisions discussed on learner's request	

Expiration date: One year of non-practice

Title	EPA 2: Manage follow-up care for a patient
Specifications and limitations	This EPA includes all key activities which a Collaborative Prescribing Practitioner needs to perform when managing or reviewing follow-up care for a patient. The specific functions which define this EPA include: 1) Review assessments and management plans from initial/ previous clinical encounter and identify relevant issues for follow-up 2) Review and clarify with targeted history taking and physical examination (if necessary) 3) Adapt treatment or management plan based on patient's response, clinical reasoning, and evidence-based practice tailored to individuals, and/ or based on existing protocols 4) Monitor patient's response to medication for efficacy and safety in concordance with the principles of therapeutic drug monitoring 5) Apply appropriate clinical reasoning to develop the most appropriate follow-up plans in partnership with patients 6) Explain and ensure that patient/ caregiver understands management plans 7) Recognize when to seek guidance and escalate care to seniors and/ or relevant members of the healthcare team 8) Document assessment findings and management plans of clinical encounter, clearly and timely, in patient's record
	Limitations: This EPA is applicable to the scope of practice defined in the Collaborative Practice Agreement or its equivalent
Sub-competencies relevant to this EPA	Full description of sub-competencies is found at end of this section

Sub-competency category	Applicable sub-competencies
Patient care ("PC")	PC1, PC2, PC3
Medical knowledge ("MK")	MK1, MK2
Practice-Based Learning and Improvement ("PBLI")	PBLI1
Professionalism ("P")	P1, P2, P3
Interpersonal and Communication Skills ("ICS")	ICS1, ICS2, ICS3

Required knowledge, skills, attitudes and experience to enable summative entrustment	**Knowledge**	• Anatomy and physiology • Advanced pathophysiology • Advanced pharmacology • Psychosocial factors that impact health outcomes • Differential diagnoses, risks and complications • Disease specific investigations (including indication), treatments, interventions and complications • Red flags • Referral processes • Pharmacokinetics and pharmacodynamics • Knowledge of pharmacology and drug interaction • Protocols, safe monitoring and side effects, including life-thretening side effects • Applied therapeutics • Available resources
	Skills	• Advanced comprehensive and systematic health assessment (mental, physical and social) and re-assessment • Interpretation, analyzation and synthetization of assessment and diagnostic investigations findings (including distinguish between normal variation and abnormal findings) • Assessment and management of side effects • Management of discontinuation and recommendation of pharmacological treatment modality • Clinical reasoning and decision-making skills • Effective interpersonal and communication skills • Clinical documentation skills • Organization skills
	Attitude	• Respectful towards patients, families and other healthcare team • Make clinical decision/s in accordance to professional standards, scope of practice and level of competence • Uphold professional attributes during patient care • Reflect on practice • Recognize own limitations and seek assistance when necessary
	Experience	Entrusted with relevant small nested EPAs: • Obtain history and perform physical examination (if necessary) • Prioritize differential diagnoses • Recommend and interpret common diagnostic and screening tests • Provide a handover in transition of care • Formulate, communicate and implement management plans • Present and document a patient encounter in the patient record

<table>
<tr><td>Source of information to support summative entrustment decision</td><td>
<table>
<tr><th>Assessment tools</th><th>Number to be completed satisfactorily</th><th>Assessors</th></tr>
<tr><td>Chart Stimulated Recall + Entrustment Based-Discussion (EBD)</td><td>At least 1</td><td>Clinical Supervisor, CPP Senior</td></tr>
<tr><td>Case Logs</td><td>At least 1</td><td>Clinical Supervisor, CPP Senior</td></tr>
</table>
</td></tr>
<tr><td>Entrustment / Supervision level expected at which stage of training.
(At the end of supervised practice)</td><td>
<table>
<tr><th>Level</th><th colspan="2">Descriptors</th><th></th></tr>
<tr><td rowspan="4">Level 3</td><td colspan="2">Indirect supervision. Supervisor is available for reactive/on-demand supervision.
The learner demonstrates independence in carrying out the full activity by himself or herself, but requires intermittent guidance / direction.</td><td></td></tr>
<tr><td>a.</td><td>All findings / decisions double checked</td><td></td></tr>
<tr><td>b.</td><td>Key findings / decisions double checked</td><td></td></tr>
<tr><td>c.</td><td>Findings / decisions discussed on learner’s request</td><td>X</td></tr>
</table>
</td></tr>
<tr><td>Expiration date</td><td>One year of non-practice</td></tr>
</table>

<table>
<tr><th>Title</th><th>EPA 3: Recognize and manage or escalate patients requiring immediate or further clinical attention</th></tr>
<tr><td>Specifications and limitations</td><td>This EPA includes all key activities which a Collaborative Prescribing Practitioner (CPP) needs to perform or escalate for further medical attention. This includes recognizing a patient requiring immediate or further care management, and escalating to relevant healthcare professional.

The specific functions which define this EPA include:
1) Recognise red flag/ abnormal physiological changes through history taking and/or physical examination
2) Recognise deteriorating or persistent abnormal investigation results and vital signs
3) Assess and determine the need for escalation of care
4) Assess and establish the patient’s Airway, Breathing, Circulation (ABC), if needed
5) Escalate to seek advance help and mobilize resources
6) Initiate or assist immediate medical care management, if needed

Limitations: This EPA is applicable to the scope of practice defined in the Collaborative Practice Agreement or its equivalent</td></tr>
<tr><td>Sub-competencies relevant to this EPA</td><td>Full description of sub-competencies is found at end of this section
<table>
<tr><th>Sub-competency category</th><th>Applicable sub-competencies</th></tr>
<tr><td>Patient care (“PC”)</td><td>PC1, PC2, PC3</td></tr>
<tr><td>Medical knowledge (“MK”)</td><td>MK1, MK2</td></tr>
<tr><td>System-Based Practice (“SBP”)</td><td>SBP1</td></tr>
<tr><td>Professionalism (“P”)</td><td>P1, P2, P3</td></tr>
<tr><td>Interpersonal and Communication Skills (“ICS”)</td><td>ICS1, ICS2, ICS3</td></tr>
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</table>

Required knowledge, skills, attitudes and experience to enable summative entrustment	**Knowledge**	• Anatomy and physiology • Advanced pathophysiology • Advanced pharmacology • Disease specific appropriate investigations (including indication), treatments, interventions and complications • Signs and symptoms of patients requiring emergent and urgent care. • Early warning scores or rapid response team/ medical emergency team criteria/ Red flags • Equipment/ devices used in the care process • Resuscitation algorithm specific to the practice setting • Roles and responsibilities of different team members in a care team
	Skills	• Focused health assessment (mental, physical and social) • Situation awareness • Interpretation, analyzation and synthetization of assessment and diagnostic findings (including distinguish between normal variation and abnormal findings) • Basic Cardiac Life Support (BCLS) or Cardiopulmonary resuscitation (CPR), Automated External Defibrillation (AED) and other life support skills • Clinical reasoning and decision-making skills • Teamwork skills • Effective interpersonal and communication skills e.g. SBAR • Clinical documentation skills • Organization skills • Ability to perform in a stressful scenario
	Attitude	• Respectful towards patients, families and other healthcare team • Make clinical decision/s in accordance to professional standards, scope of practice and level of competence • Uphold professional attributes during patient care • Reflect on practice • Recognize own limitations and seek assistance when necessary
	Experience	1. The CPP has valid BCLS or CPR and AED certifications 2. Entrusted with relevant small nested EPAs: • Obtain history and perform physical examination (if necessary) • Vital signs interpretation and analysis • Recommend and interpret common diagnostic and screening tests • Basic life-threatening arrhythmias recognition • Basic life support and post-cardiac arrest care • Provide a handover in transition of care • Formulate, communicate and implement management plans • Present and document a patient encounter in the patient record

Source of information to support summative entrustment decision

Assessment tools	Number to be completed satisfactorily	Assessors
Chart Stimulated Recall + Entrustment Based-Discussion (EBD)	At least 1	Clinical Supervisor, CPP Senior

Entrustment / Supervision level expected at which stage of training. (At the end of supervised practice)

Level	Descriptors		
Level 3	**Indirect supervision. Supervisor is available for reactive/on-demand supervision.** The learner demonstrates independence in carrying out the full activity by himself or herself, but requires intermittent guidance / direction.		
	a.	All findings / decisions double checked	**X**
	b.	Key findings / decisions double checked	
	c.	Findings / decisions discussed on learner's request	

Expiration date: One year of non-practice

EPAs for Adult Collaborative Prescribing

Title	EPA 4: Manage care transitions between healthcare professionals within and between healthcare settings
Specifications and limitations	This EPA includes all key activities required of a Collaborative Prescribing Practitioner in handing over patients from encounter to encounter, transitioning or discharging care of patient across settings. It can be performed in various health and social care settings such as hospitals, community etc. The specific functions which define this EPA include: 1) Assess needs for transition of care within and between healthcare settings 2) Discuss and communicate with patient, family, healthcare team members and/ or community partners on transition of care 3) Develop a plan for care transition in accordance with patient's care needs, goals and preferences 4) Provide information, education and training required for continuity of care 5) Initiate appropriate referrals/ handovers 6) Recommend, facilitate, and provide relevant resources required to ensure smooth transitions of care 7) Arrange and ensure a safe and smooth transition within or between healthcare settings 8) Coordinate patient care and follow up accordingly 9) Maintain proper documentation of relevant elements of the consultation and handovers reports of patient's transitional care needs
	Limitations: This EPA is applicable to the scope of practice defined in the Collaborative Practice Agreement or its equivalent
Sub-competencies relevant to this EPA	Full description of sub-competencies is found at end of this section

Sub-competency category	Applicable sub-competencies
Patient care ("PC")	PC1, PC2, PC3
Medical knowledge ("MK")	MK1
System-Based Practice ("SBP")	SBP1
Professionalism ("P")	P1, P2, P3
Interpersonal and Communication Skills ("ICS")	ICS1, ICS2, ICS3

Required knowledge, skills, attitudes and experience to enable summative entrustment	**Knowledge**	• Knowledge to triage the different patients' needs to be managed at the different care settings • Resources available within inpatient, specialist outpatient and community care settings • The process to initiate appropriate referrals to various healthcare professionals and/ or care settings • The process of coordination and follow up on transition of care • Roles and responsibilities of different stakeholders directly or indirectly involved in the transition of care
	Skills	• Clinical reasoning and decision-making skills • Effective interpersonal and communication skills • Care coordination and case management skills • Clinical documentation skills
	Attitude	• Respectful towards patients, families and other healthcare team members • Make clinical decision in accordance with professional standards, scope of practice and level of competence • Uphold professional attributes during transition of care • Reflect on practice • Recognize own limitations and seek assistance when necessary
	Experience	Entrusted with relevant small nested EPAs: • Provide a handover in transition of care • Formulate, communicate and implement management plans • Present and document a patient encounter in the patient record

Source of information to support summative entrustment decision

Assessment tools	Number to be completed satisfactorily	Assessors
Case Log + Entrustment Based-Discussion (EBD)	At least 1	Clinical Supervisor, CPP Senior

Entrustment / Supervision level expected at which stage of training. (At the end of supervised practice)

Level	Descriptors		
Level 3	**Indirect supervision. Supervisor is available for reactive/on-demand supervision.** The learner demonstrates independence in carrying out the full activity by himself or herself, but requires intermittent guidance / direction.		
	a.	All findings / decisions double checked	
	b.	Key findings / decisions double checked	**X**
	c.	Findings / decisions discussed on learner's request	

Expiration date	One year of non-practice

Title	EPA 5: Collaborate with patients, families, and community to improve health through disease prevention and health promotion
Specifications and limitations	This EPA includes all key activities which a Collaborative Prescribing Practitioner (CPP) needs to perform for patients who will benefit from relevant health screening, disease prevention or health promotion programmes. It can be performed in various healthcare settings including hospitals and the community. The specific functions which define this EPA include: 1) Recommend appropriate health screening services/ vaccinations that are tailored to individual health concerns, age, risk factors, medical and family history 2) Develop care plan with individual/ their families to address their health problems and goals in a manner that reflects their needs, values, preferences and responsibility in controlling them 3) Provide patients and their families with information and education that will enable them to improve health, make healthy life choices, assume self-care and cope with acute/ chronic illnesses 4) Refer individuals and/ or families to other healthcare professionals and/ or community resources where appropriate 5) Discuss follow-up plans with patients, their families and the healthcare team
	Limitations: This EPA is applicable to the scope of practice defined in the Collaborative Practice Agreement or its equivalent
Sub-competencies relevant to this EPA	Full description of sub-competencies is found at end of this section

Sub-competency category	Applicable sub-competencies
Patient care ("PC")	PC1, PC2, PC3
Medical knowledge ("MK")	MK1, MK2
System-Based Practice ("SBP")	SBP1
Practice-Based Learning and Improvement ("PBLI")	PBLI1
Professionalism ("P")	P1, P2, P3
Interpersonal and Communication Skills ("ICS")	ICS1, ICS2, ICS3

Required knowledge, skills, attitudes and experience to enable summative entrustment	**Knowledge**	• Common health conditions, including symptoms preceding and of disease, disease trajectory, risk factors for disease and methods to modify risk • Evidence based guidelines on health screening, including risks, benefits, costs, alternatives of screening, common fears and misconceptions • Interpretation of screening test results • Type of vaccinations and their appropriate schedule • Modifiable and non-modifiable determinants of health, risk factors and health behaviors (including stages of behavioral change) • Health promotion and disease prevention • Healthy life choices (including diet, lifestyle, and etc) • Adult learning and motivation principles • Available community resources • The process to initiate appropriate referrals to various healthcare professionals and/ or care settings
	Skills	• Clinical reasoning and decision-making skills • Effective interpersonal and communication skills • Motivational interviewing / health coaching skills • Teaching / facilitation skills • Clinical documentation skills
	Attitude	• Respectful towards patients, families and other healthcare team • Make clinical decision/s in accordance to professional standards, scope of practice and level of competence • Uphold professional attributes during transition of care • Reflect on practice • Recognize own limitations and seek assistance when necessary
	Experience	Entrusted with relevant small nested EPAs: • Formulate, communicate and implement management plans • Present and document a patient encounter in the patient record • Engage patient/family in in health promotion and disease prevention through education

Source of information to support summative entrustment decision	<table><tr><th>Assessment tools</th><th>Number to be completed satisfactorily</th><th>Assessors</th></tr><tr><td>Mini CEX* + Entrustment Based-Discussion (EBD)</td><td>At least 1</td><td>Clinical Supervisor, CPP Senior</td></tr></table> *If unable to complete mini-CEX, may substitute with a caselog. To undertake the second mini-CEX for EPA 1 or EPA 2.
Entrustment / Supervision level expected at which stage of training. (At the end of supervised practice)	<table><tr><th>Level</th><th colspan="2">Descriptors</th><th></th></tr><tr><td rowspan="4">Level 3</td><td colspan="2">Indirect supervision. Supervisor is available for reactive/on-demand supervision. The learner demonstrates independence in carrying out the full activity by himself or herself, but requires intermittent guidance / direction.</td><td></td></tr><tr><td>a.</td><td>All findings / decisions double checked</td><td></td></tr><tr><td>b.</td><td>Key findings / decisions double checked</td><td>X</td></tr><tr><td>c.</td><td>Findings / decisions discussed on learner's request</td><td></td></tr></table>
Expiration date	One year of non-practice

Title	**EPA 6 (Additional): Plan, perform procedure(s) and evaluate outcome of the procedure(s)**
Specifications and limitations	This EPA includes all key activities which a Collaborative Prescribing Practitioner needs to perform specialty-appropriate procedures to meet the health care needs of individual patients. The specific functions which define this EPA include: 1) Determine need for procedure 2) Explain rationale, benefits and risk of procedure(s) to patients and caregivers, and obtain consent 3) Provide comfort and reassurance to patient throughout procedures 4) Perform procedures in accordance to background knowledge of indications, contraindications, complications and skills of procedures 5) Apply principles of infection prevention and control 6) Monitor and evaluate outcomes benefits or untoward effects/ and manage common post-procedure complications (where appropriate) 7) Document observations in medical record and report issues *(Instructions to Trainee. You should customize the EPAs by listing down the list of procedures in your scope of collaborative prescribing practice.)* **Limitations:** This EPA is applicable to the scope of practice defined in the Collaborative Practice Agreement or its equivalent
Sub-competencies relevant to this EPA	Full description of sub-competencies is found at end of this section <table><tr><th>Sub-competency category</th><th>Applicable sub-competencies</th></tr><tr><td>Patient care ("PC")</td><td>PC1, PC2, PC3</td></tr><tr><td>Medical knowledge ("MK")</td><td>MK1, MK2</td></tr><tr><td>System-Based Practice ("SBP")</td><td>SBP1</td></tr><tr><td>Practice-Based Learning and Improvement ("PBLI")</td><td>PBLI1</td></tr><tr><td>Professionalism ("P")</td><td>P1, P2, P3</td></tr><tr><td>Interpersonal and Communication Skills ("ICS")</td><td>ICS1, ICS2, ICS3</td></tr></table>

<table>
<tr><td rowspan="4">Required knowledge, skills, attitudes and experience to enable summative entrustment</td><td>Knowledge</td><td>• Anatomy and physiology
• Advanced pathophysiology
• Advanced pharmacology
• Psychosocial factors that impact health outcomes
• Differential diagnoses, risks and complications
• Disease specific investigations (including indication), treatments, interventions and complications
• Red flags
• Referral processes
• Available resources</td></tr>
<tr><td>Skills</td><td>• Perform procedural skills
• Clinical reasoning and decision-making skills
• Effective interpersonal and communication skills
• Organization skills
• Clinical documentation skills</td></tr>
<tr><td>Attitude</td><td>• Respectful towards patients, families and other healthcare team
• Make clinical decision/s in accordance to professional standards, scope of practice and level of competence
• Uphold professional attributes during patient care
• Reflect on practice
• Recognize own limitations and seek assistance when necessary</td></tr>
<tr><td>Experience</td><td>Entrusted with relevant small nested EPAs:
• Obtain history and perform physical examination
• Prioritize differential diagnoses
• Recommend and interpret common diagnostic and screening tests
• Provide a handover in transition of care
• Formulate, communicate and implement management plans
• Present and document a patient encounter in the patient record
• Operate equipment / device needed for the procedures</td></tr>
<tr><td>Source of information to support summative entrustment decision</td><td colspan="2"><table><tr><th>Assessment tools</th><th>Number to be completed satisfactorily</th><th>Assessors</th></tr><tr><td>Direct Observation of Procedural Skills (DOPS) + Entrustment Based-Discussion (EBD)</td><td>At least 1 for each procedure</td><td>Clinical Supervisor</td></tr></table></td></tr>
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The learner is able to carry out the full activity by himself or herself but requires constant guidance / direction. The supervisor is in the room watching and can intervene or take over at any time deemed necessary.</td></tr><tr><td>a.</td><td>PA conducted as a co-activity with supervisor</td><td>X</td></tr><tr><td>b.</td><td>EPA conducted alone, with supervisor in the room; ready to step in as needed</td><td></td></tr></table></td></tr>
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<table>
<tr><th>Title</th><th>EPA 7 (Additional): Manage care of patients with chronic, advanced, or end-stage diseases across care settings</th></tr>
<tr><td rowspan="2">Specifications and limitations</td><td>This EPA includes all key activities which a Collaborative Prescribing Practitioner (CPP) needs to perform when managing patients with chronic, advanced, or end-stage diseases across care settings.

The specific functions which define this EPA include:
1) Acquire accurate and relevant history from patient and or/ caregiver
2) Recognize disease presentations that deviate from common patterns and require complex decision making
3) Customize care in the context of the patient's preferences and overall health
4) Address patients and/ or caregiver concerns
5) Provide support (physical, psychological, social, and spiritual) for dying patients and their families
6) Review need for referrals to interdisciplinary teams
7) Provide periodic follow-up care to patient as and when necessary
8) Recognize when to seek guidance and escalate care to senior and/or relevant members of the healthcare team
9) Document encounter in the patient record accurately</td></tr>
<tr><td>Limitations: This EPA is applicable to the scope of practice defined in the Collaborative Practice Agreement or its equivalent</td></tr>
<tr><td>Sub-competencies relevant to this EPA</td><td>Full description of sub-competencies is found at end of this section<table><tr><th>Sub-competency category</th><th>Applicable sub-competencies</th></tr><tr><td>Patient care ("PC")</td><td>PC1, PC2, PC3</td></tr><tr><td>Medical knowledge ("MK")</td><td>MK1, MK2</td></tr><tr><td>System-Based Practice ("SBP")</td><td>SBP1</td></tr><tr><td>Practice-Based Learning and Improvement ("PBLI")</td><td>PBLI1</td></tr><tr><td>Professionalism ("P")</td><td>P1, P2, P3</td></tr><tr><td>Interpersonal and Communication Skills ("ICS")</td><td>ICS1, ICS2, ICS3</td></tr></table></td></tr>
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<table>
<tr><td rowspan="4">Required knowledge, skills, attitudes and experience to enable summative entrustment</td><td>Knowledge</td><td>• Advanced pathophysiology and pharmacology
• Socio-behavioral sciences including but not limited to healthcare economics, medical ethics and organizational policy
• Ethical knowledge
• Documentation process
• Hospital administrative policies
• Reporting policies and procedures</td></tr>
<tr><td>Skills</td><td>• Critical thinking skills
• Clinical reasoning and decision-making skills
• Effective interpersonal and communication skills
• Clinical documentation skills
• Make clinical decision(s) in accordance to professional standards, scope of practice and level of competence</td></tr>
<tr><td>Attitude</td><td>• Respectful towards patients, caregivers and other members of the healthcare team
• Tactful and patience when communicating with patients and caregivers
• Demonstrate empathy and compassion to patients and/or caregiver
• Demonstrate a commitment to relieve pain and suffering
• Uphold professional attitude during all encounters
• Reflect on own practice
• Recognize own limitations and seek assistance when necessary</td></tr>
<tr><td>Experience</td><td>Entrusted with relevant small nested EPAs:
• Obtain history and perform physical examination (if necessary)
• Prioritize differential diagnoses
• Recommend and interpret common diagnostic and screening tests
• Provide a handover in transition of care
• Formulate, communicate and implement management plans
• Present and document a patient encounter in the patient record</td></tr>
<tr><td>Source of information to support summative entrustment decision</td><td colspan="2"><table><tr><th>Assessment tools</th><th>Number to be completed satisfactorily</th><th>Assessors</th></tr><tr><td>Case Logs + Entrustment Based-Discussion (EBD)</td><td>At least 1</td><td>Clinical Supervisor</td></tr></table></td></tr>
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<tr><td>Expiration date</td><td colspan="2">One year of non-practice</td></tr>
</table>

Title	EPA 8 (Additional): Manage care of perioperative patients
Specifications and limitations	This EPA includes all key activities which a Collaborative Prescribing Practitioner needs to perform whenever a patient is admitted for elective/ emergency procedure/ surgery. The specific functions which define this EPA include: 1) Acquire accurate and relevant history from patient/ caregiver 2) Review all relevant information from the electronic medical record system/ old notes 3) Perform accurate physical examination that is appropriately targeted to patient’s complaints and medical condition 4) Identify pertinent abnormalities using common maneuvers 5) Synthesize all available data, including interview, physical examination, preliminary laboratory data, to define the appropriate pre and post procedure/ surgery management 6) Establish and implement a care plan to optimize chronic diseases and risk factors to improve surgical outcomes 7) Establish and implement a care plan for peri-operative/ procedure including patient education and peri-procedure/ surgery instructions 8) Counsel patients/ caregivers about risk and benefits of procedures/ surgery appropriately, highlighting cost awareness and resource allocation (if appropriate to the roles) 9) Actively seek to understand patient differences and views and reflects this in respectful communication and shared decision-making with the patient and the healthcare team 10) Ensure succinct, relevant, and patient-specific documentation that is congruent with organization’s protocols **Limitations:** This EPA is applicable to the scope of practice defined in the Collaborative Practice Agreement or its equivalent

<table>
<tr><td>Sub-competencies relevant to this EPA</td><td colspan="2">Full description of sub-competencies is found at end of this section
<table><tr><th>Sub-competency category</th><th>Applicable sub-competencies</th></tr><tr><td>Patient care (“PC”)</td><td>PC1, PC2, PC3</td></tr><tr><td>Medical knowledge (“MK”)</td><td>MK1, MK2</td></tr><tr><td>System-Based Practice (“SBP”)</td><td>SBP1</td></tr><tr><td>Practice-Based Learning and Improvement (“PBLI”)</td><td>PBLI1</td></tr><tr><td>Professionalism (“P”)</td><td>P1, P2, P3</td></tr><tr><td>Interpersonal and Communication Skills (“ICS”)</td><td>ICS1, ICS2, ICS3</td></tr></table></td></tr>
<tr><td rowspan="4">Required knowledge, skills, attitudes and experience to enable summative entrustment</td><td>Knowledge</td><td>• Anatomy and physiology of the system in relation to the performed procedure
• Organization protocols and standard operating procedures
• Common procedural indications, contraindications, limitations, risks and benefits
• Comorbidities that may complicate anesthesia or surgery
• Preventative strategies to reduce post-operative complications
• Potential complications and red flags of the performed procedures
• Pre- and post-procedure management of patients
• Management of medically complex patients</td></tr>
<tr><td>Skills</td><td>• Advanced physical examination
• Interpretation, analyzation and synthetization of assessment and diagnostic investigations findings
• Clinical reasoning and decision-making skills
• Effective interpersonal and communication skills
• Clinical documentation skills
• Organization skills</td></tr>
<tr><td>Attitude</td><td>• Respectful towards patients, families and other healthcare team
• Make clinical decision/s in accordance to professional standards, scope of practice and level of competence
• Uphold professional attributes during patient care
• Recognize own limitations and seek assistance when necessary</td></tr>
<tr><td>Experience</td><td>Entrusted with relevant small nested EPAs:
• Obtain history and perform physical assessment
• Formulate and prioritize differential diagnoses
• Recommend and interpret diagnostic and screening test</td></tr>
</table>

<table>
<tr><td>Source of information to support summative entrustment decision</td><td><table><tr><th>Assessment tools</th><th>Number to be completed satisfactorily</th><th>Assessors</th></tr><tr><td>Case Logs + Entrustment Based-Discussion (EBD)</td><td>At least 1</td><td>Clinical Supervisor, CPP Senior</td></tr></table></td></tr>
<tr><td>Entrustment / Supervision level expected at which stage of training.
(At the end of supervised practice)</td><td><table><tr><th>Level</th><th colspan="2">Descriptors</th><th></th></tr><tr><td rowspan="4">Level 3</td><td colspan="2">Indirect supervision. Supervisor is available for reactive/on-demand supervision.
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<tr><td>Expiration date</td><td>At least 1 year of non-clinical practice will require re-entrustment and fulfilment of recommended assessments</td></tr>
</table>

Title	EPA 9 (Additional): Manage patients with chronic pain
Specifications and limitations	This EPA includes all key activities which a Collaborative Prescribing Practitioner needs to perform when managing patients with chronic pain. The specific functions which define this EPA include: 1) Acquire accurate and relevant history from patient and/ or caregiver 2) Perform appropriate physical examination that is targeted to patient's complaints and medical condition. Identify pertinent abnormalities using common maneuvers 3) Synthesize all available data, including interview, physical examination, preliminary laboratory data, and patient preference to define the appropriate management 4) Initiate initial intervention(s), if needed, to relieve pain and suffering 5) Make appropriate clinical decision based on the results of advanced diagnostic tests 6) Review need for referrals to interdisciplinary teams 7) Recognize when to seek guidance and escalate care to senior and/ or relevant members of the healthcare team 8) Document encounter in the patient record accurately 9) Manage controlled drug use and supply with patient, if relevant **Limitations:** This EPA is applicable to the scope of practice defined in the Collaborative Practice Agreement or its equivalent
Sub-competencies relevant to this EPA	Full description of sub-competencies is found at end of this section

Sub-competency category	Applicable sub-competencies
Patient care ("PC")	PC1, PC2, PC3
Medical knowledge ("MK")	MK1, MK2
System-Based Practice ("SBP")	SBP1
Practice-Based Learning and Improvement ("PBLI")	PBLI1
Professionalism ("P")	P1, P2, P3
Interpersonal and Communication Skills ("ICS")	ICS1, ICS2, ICS3

Required knowledge, skills, attitudes and experience to enable summative entrustment	**Knowledge**	• Advanced pathophysiology and pharmacology • Ethical knowledge • Documentation process
	Skills	• Critical thinking skills • Clinical reasoning and decision-making skills • Effective interpersonal and communication skills • Clinical documentation skills
	Attitude	• Respectful towards patients, families and other healthcare team • Exercise empathy, tactfulness and patience when communicating with patients and caregivers • Reflect on practice • Make clinical decision/s in accordance to professional standards, scope of practice and level of competence • Uphold professional attributes during patient care • Recognize own limitations and seek assistance when necessary
	Experience	Entrusted with relevant small nested EPAs: • Obtain history and perform physical examination (if necessary) • Prioritize differential diagnoses • Recommend and interpret common diagnostic and screening tests • Present and document an encounter in the patient record

Source of information to support summative entrustment decision

Assessment tools	Number to be completed satisfactorily	Assessors
Case Logs + Entrustment Based-Discussion (EBD)	At least 1	Clinical Supervisor

Entrustment / Supervision level expected at which stage of training. (At the end of supervised practice)

Level	Descriptors		
Level 3	**Indirect supervision. Supervisor is available for reactive/on-demand supervision.** The learner demonstrates independence in carrying out the full activity by himself or herself, but requires intermittent guidance / direction.		
	a.	All findings / decisions double checked	
	b.	Key findings / decisions double checked	**X**
	c.	Findings / decisions discussed on learner's request	

Expiration date	One year of non-practice

Sub-Competencies

PC	Patient Care
PC1	Gathers and Synthesizes Essential and Accurate Information to Define Each Patient's Clinical Problem(s): • Acquires accurate histories from patients in an efficient, prioritized, and hypothesis-driven fashion • Performs accurate and efficient physical exams that are targeted to the patient's complaints • Synthesizes data to generate a prioritized differential diagnosis and other related medical problems • Effectively uses history and physical examination skills to minimize the need for further diagnostic testing
PC2	Develops and Achieves Comprehensive Management Plan for Each Patient: • Appropriately modifies care plans based on patient's clinical course, additional data, and patient preferences • Manages both acute and chronic medical issues proficiently and takes into consideration their interrelation in development of management plan • Consistently plans for patient's discharge in advance and considers early intervention for barriers to care
PC3	Requesting Referrals and Escalating Care: • Asks specific and relevant questions in a succinct manner when making referrals • Gathers information accurately and completely. Organizes it in a manner which facilitates the referral consultation • Identifies patients who are in distress and/or clinically unstable and informs seniors in a timely manner after attempts to assess patients and institute preliminary measures appropriately.
MK	**Medical Knowledge**
MK1	Clinical Knowledge: • Possesses the scientific, socioeconomic, and behavioral knowledge required to provide holistic patient care for complex medical conditions.
MK2	Knowledge of Diagnostic Testing and Procedures: • Consistently interprets basic and advanced diagnostic tests accurately and relates to clinical context • Understands the concepts of pre-test probability and test performance characteristics to be able to choose the best test for the patient • Fully understands the rationale and risks associated with all common tests

EPAs for Adult Collaborative Prescribing

Sub-Competencies

SBP	System-Based Practice
SBP1	System Navigation for Patient-Centred Care: • Identifies patients' priorities and values • Requires guidance to relate them to the clinical targets and management plans. Makes attempt to involve patient in care planning • Understands the roles of members within inter-professional teams and leverages on them to achieve clinical targets with reduced supervision • Recommends and utilises resources to return patients to state of health within the community. Requires guidance in seeking patients and family's understanding and acceptance of how
PBLI	**Practice-Based Learning and Improvement**
PBLI1	Evidence-Based and Informed Practice: • Critically appraises and applies evidence even in the face of uncertainty and conflicting evidence to guide care, tailored to the individual patient
P	**Professionalism**
P1	Professional Behavior and Ethical Principles: • Recognizes situations that may trigger professionalism lapses and intervenes to prevent lapses in self and others • Analyzes complex situations using ethical principles and consistently applies them in managing situations of ethical dilemma • Seeks help consistently for complex ethical situations after making preliminary attempts to address issue
P2	Accountability and Conscientiousness: • Takes ownership for all patients assigned to self. Follows through completely on all identified tasks. and ensures complete implementation of orders within care plans • Bears responsibility for gaps by adopting measures to close decision loops. • Considers factors contributing to lapses and how they can be prevented.
P3	Self-Awareness and Help-Seeking • Independently develops a plan to optimize personal and professional well- being • Independently develops a plan to remediate or improve limits in the knowledge/ skills of self

Sub-Competencies

ICS	Interpersonal and Communication Skills
ICS1	Patient- and Family-Centred Communication: • Easily establishes therapeutic relationships, with attention to patient/family concerns and context, regardless of complexity • Independently recognizes personal biases while attempting to proactively minimize communication barriers • Independently uses shared decision making to align patient/family values, goals, and preferences with treatment options to make a personalized care plan
ICS2	Interprofessional and Team Communication: • Listens actively to inputs from members in primary and inter-professional team to understand and appreciate their perspectives • Proactively clarifies when in doubt before forming conclusions • Clear and respectful in communication (including provision of feedback and handling disagreement) with colleagues and superiors
ICS3	Communication within Health Care Systems: • Communicates clearly, concisely, in a timely manner, and in an organized written form, including anticipatory guidance • Produces written or verbal communication (e.g., patient notes, e-mail, etc.) that serves as an example for others to follow • Initiates difficult conversations with appropriate stakeholders to improve the system

EPAs for Paediatric Collaborative Prescribing Practitioners ("CPPs")

	EPA titles	EPA Category (APN)	EPA Category (Pharmacist)	Entrustment level
1	Identifying, diagnosing and managing children with acute, common paediatric conditions in an ambulatory or inpatient setting	Core	Core	3a
2	Managing follow-up care for children	Core	Additional	3a
3	Recognize and manage or escalate patients requiring immediate or further clinical attention	Core	Additional	2b
4	Managing care transitions between healthcare professionals and/or settings	Core	Additional	3a
5	Collaborate with patients, families, and community to improve health through disease prevention and health promotion	Core	Core	3a
6	Identifying, diagnosing and managing children with behavioural and developmental concerns	Additional	Additional	3a
7	Assisting in the procedures in the management of critically and severely ill children	Additional	Additional	2b

Title	EPA 1: Identifying, diagnosing and managing children with acute, common paediatric conditions in an ambulatory or inpatient setting
Specifications and limitations	This activity includes all key activities which a collaborative prescribing practitioner (CPP) needs to perform whenever a patient is reviewed, admitted, transferred or before any care procedure for forward care planning. The CPP must be able to recognize and manage common acute paediatric conditions (medical and surgical), assessing the severity of illness and using judgment as to whether immediate or emergency intervention, stabilization, or transfer to a higher acuity facility are necessary for treatment of urgent or life-threatening conditions. This activity contains the following elements: 1) Gather information through thorough history taking 2) Perform physical examination 3) Order or propose investigations if required 4) Interpret investigation results if required 5) Develop main and differential diagnoses based on findings 6) Adapt treatment based on clinical reasoning and evidence-based practice tailored to individuals and /or based on existing protocols 7) Recognize when to seek guidance and escalate care to seniors and/or relevant members of the healthcare team and follow up accordingly 8) Initiate appropriate referrals to interdisciplinary teams based on findings 9) Provide appropriate counselling and education to patients and families 10) Document clinical encounter in the patient record
	Limitations: This EPA is applicable to the scope of practice defined in the Collaborative Practice Agreement or its equivalent
Sub-competencies relevant to this EPA	Full description of sub-competencies is found at end of this document

Sub-competency category	Applicable sub-competencies
Patient care ("PC")	PC1, PC2, PC3
Medical knowledge ("MK")	MK1, MK2
System-Based Practice ("SBP")	SBP1
Practice-Based Learning and Improvement ("PBLI")	PBLI1
Professionalism ("P")	P1, P2, P3
Interpersonal and Communication Skills ("ICS")	ICS1, ICS2, ICS3

Required knowledge, skills, attitudes and experience to enable summative entrustment	**Knowledge**	• Anatomy and physiology. Advanced pathophysiology. Advanced pharmacotherapy and applied therapeutics • Differential diagnoses, risks and complications • Disease specific investigations (including indication), treatments, interventions and complications • Monitoring of disease progression and red flags • Psychosocial factors that impact health outcomes • Anticipatory guidance around normal growth behaviour and development, parenting and prevention of diseases and injury • Referral processes • Available resources • Normal paediatric growth behaviour and development (patterns of growth, nutrition and dietary transitions, motor, language and cognitive developmental milestones, socio-emotional and behavioural health, immunization schedule) • Age-appropriate screening tools and test
	Skills	• In-depth history taking skills • Recognition of abnormalities in growth, developmental milestones, and/or puberty • Interpretation, analysis and synthesis of assessment and diagnostic investigations findings (including competency in distinguishing between normal variation and abnormal findings) • Selection of appropriate screening tests and interpretation of their respective results (e.g. chest x-rays, laboratory tests) • Clinical reasoning and decision-making skills • Recognition of cases and situations to refer to/involve other healthcare professionals and colleagues • Effective communication skills with healthcare team and patient's family • Competency in provision of education and counselling to patients and their families • Clinical documentation skills and organization skills For APNs Only • Advanced comprehensive health assessment (mental, physical and social) and re-assessment • Selection and interpretation of appropriate screening tools and tests and their respective results (e.g. screening for growth and development, special senses, and medical conditions) • Coordination of care
	Attitude	• Respectful towards patients, families and other healthcare team • Make clinical decision/s in accordance to professional standards, scope of practice and level of competence • Uphold professional attributes during patient care • Reflect on practice • Recognise own limitations and seek assistance when necessary

<table>
<tr><td>Required knowledge, skills, attitudes and experience to enable summative entrustment</td><td>Experience</td><td>Entrusted with relevant small nested EPAs:
• Obtain history
• Perform physical examination
• Prioritize differential diagnoses
• Recommend and interpret common diagnostic and screening tests
• Provide a handover in transition of care
• Formulate, communicate and implement management plans
• Present and document a patient encounter in the patient record</td></tr>
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<tr><th>Assessment tools</th><th>Number to be completed satisfactorily</th><th>Assessors</th></tr>
<tr><td>Mini-CEX + Entrustment Based-Discussion (EBD)</td><td>At least 1</td><td>Clinical Supervisor
CPP Preceptor</td></tr>
<tr><td>Case Logs</td><td>At least 1</td><td>Clinical Supervisor
CPP Preceptor</td></tr>
<tr><td>Evaluation</td><td>At least 1</td><td>Clinical Supervisor
CPP Preceptor</td></tr>
<tr><td>Multisource Feedback</td><td>At least 1</td><td>4 raters to be determined jointly by learner and supervisor</td></tr>
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<tr><td>Entrustment / Supervision level expected at which stage of training.
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<tr><th>Level</th><th colspan="2">Descriptors</th><th></th></tr>
<tr><td rowspan="4">Level 3</td><td colspan="2">Indirect supervision. Supervisor is available for reactive/on-demand supervision.
The learner demonstrates independence in carrying out the full activity by himself or herself, but requires intermittent guidance / direction.</td><td></td></tr>
<tr><td>a.</td><td>All findings / decisions double checked</td><td>X</td></tr>
<tr><td>b.</td><td>Key findings / decisions double checked</td><td></td></tr>
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</table>

<table>
<tr><th>Title</th><th>EPA 2 (Core EPA for APNs, Additional EPA for Pharmacists): Managing follow-up care for children</th></tr>
<tr><td>Specifications and limitations</td><td>This activity includes all key activities which a CPP needs to perform when managing or reviewing follow-up care for a patient.

This activity contains the following elements:

1) Review assessments and management plans from initial/previous clinical encounter and identify relevant issues for follow-up

2) Review and clarify with targeted history taking

3) Perform physical examination

4) Adapt treatment plan based on clinical reasoning and evidence-based practice tailored to individuals, and /or based on existing protocols

5) Recognize when to seek guidance and escalate care to seniors and/or relevant members of the healthcare team and follow up accordingly

6) Provide appropriate counselling and education to patients and families

7) Document assessment findings and management plans after clinical encounter

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<tr><td>Sub-competencies relevant to this EPA</td><td>Full description of sub-competencies is found at end of this document

<table>
<tr><th>Sub-competency category</th><th>Applicable sub-competencies</th></tr>
<tr><td>Patient care (“PC”)</td><td>PC1, PC2, PC3</td></tr>
<tr><td>Medical knowledge (“MK”)</td><td>MK1, MK2</td></tr>
<tr><td>System-Based Practice (“SBP”)</td><td>SBP1</td></tr>
<tr><td>Practice-Based Learning and Improvement (“PBLI”)</td><td>PBLI1</td></tr>
<tr><td>Professionalism (“P”)</td><td>P1, P2, P3</td></tr>
<tr><td>Interpersonal and Communication Skills (“ICS”)</td><td>ICS1, ICS2, ICS3</td></tr>
</table></td></tr>
</table>

Required knowledge, skills, attitudes and experience to enable summative entrustment	**Knowledge**	• Anatomy and physiology. Advanced pathophysiology. Advanced pharmacotherapy and applied therapeutics • Differential diagnoses, risks, and complications • Disease specific investigations (including indication), treatments, interventions and complications • Psychosocial factors that impact health outcomes • Red flags • Anticipatory guidance around normal growth behaviour and development, parenting and prevention of diseases and injury • Referral processes • Available resources • Normal paediatric growth behaviour and development (patterns of growth, nutrition and dietary transitions, motor, language and cognitive developmental milestones, socio-emotional and behavioural health, immunization schedule) • Age-appropriate screening tools and test
	Skills	• In-depth history taking skills • Recognition of abnormalities in growth, developmental milestones, and/or puberty • Selection and interpretation of appropriate diagnostic investigations in monitoring of disease states • Clinical reasoning and decision-making skills • Recognition of cases and situations to refer to / involve other healthcare professionals and colleagues • Effective interpersonal and communication skills • Competency in provision of education and counselling to patients and their families • Clinical documentation skills and organization skills For APNs Only • Advanced comprehensive health assessment (mental, physical and social) and re-assessment • Selection and interpretation of appropriate screening tools and tests and their respective results (e.g. screening for growth and development, special senses, and medical conditions) • Coordination of care
	Attitude	• Respectful towards patients, families and other healthcare team • Make clinical decision/s in accordance to professional standards, scope of practice and level of competence • Uphold professional attributes during patient care • Reflect on practice • Recognise own limitations and seek assistance when necessary

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<tr><td>Required knowledge, skills, attitudes and experience to enable summative entrustment</td><td>Experience</td><td>Entrusted with relevant small nested EPAs:
• Obtain history
• Perform physical examination
• Prioritize differential diagnoses
• Recommend and interpret common diagnostic tests
• Provide a handover in transition of care
• Formulate, communicate and implement management plans
• Present and document a patient encounter in the patient record</td></tr>
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<tr><th>Assessment tools</th><th>Number to be completed satisfactorily</th><th>Assessors</th></tr>
<tr><td>Case-based Discussion (CBD) + Entrustment Based-Discussion (EBD)</td><td>At least 1</td><td>Clinical Supervisor
CPP Preceptor</td></tr>
<tr><td>Case Logs</td><td>At least 1</td><td>Clinical Supervisor
CPP Preceptor</td></tr>
<tr><td>Evaluation</td><td>At least 1</td><td>Clinical Supervisor
CPP Preceptor</td></tr>
</table></td></tr>
<tr><td>Entrustment / Supervision level expected at which stage of training.
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<tr><td rowspan="4">Level 3</td><td colspan="2">Indirect supervision. Supervisor is available for reactive/on-demand supervision.
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<tr><td>a.</td><td>All findings / decisions double checked</td><td>X</td></tr>
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</table></td></tr>
<tr><td>Expiration date</td><td colspan="2">At least 1 year of non-clinical practice will require re-entrustment and fulfilment of recommended assessments</td></tr>
</table>

Title	EPA 3 (Core EPA for APNs, Additional EPA for Pharmacists): Recognize and manage or escalate patients requiring immediate or further clinical attention
Specifications and limitations	This activity includes all key activities which a CPP needs to perform when assessing, managing, or reviewing care for a critical or severely ill patient. This activity contains the following elements: 1) Targeted history taking with or without physical examination 2) Recognition of the abnormal physiological/ vital signs changes 3) Formulate an initial plan of investigation based on diagnostic hypotheses 4) Interpret and communicate results of diagnostic tests, including recognising deteriorating or persistent abnormal investigations results 5) Assess and establish the patient's Airway, Breathing, Circulation (ABC) 6) Initiate immediate medical care management, if needed 7) Escalate to seek advance help and mobilize resources, if needed 8) Handing over the care of patients to a high-dependency or intensive care unit 9) Document in medical record and report issues
	Limitations: This EPA is applicable to the scope of practice defined in the Collaborative Practice Agreement or its equivalent
Sub-competencies relevant to this EPA	Full description of sub-competencies is found at end of this document

Sub-competency category	Applicable sub-competencies
Patient care ("PC")	PC1, PC2, PC3
Medical knowledge ("MK")	MK1, MK2
System-Based Practice ("SBP")	SBP1
Practice-Based Learning and Improvement ("PBLI")	PBLI1
Professionalism ("P")	P1, P2, P3
Interpersonal and Communication Skills ("ICS")	ICS1, ICS2, ICS3

Required knowledge, skills, attitudes and experience to enable summative entrustment	**Knowledge**	• Anatomy and physiology. Advanced pathophysiology. Advanced pharmacotherapy and applied therapeutics. • Recognize signs and symptoms of patients requiring emergent and urgent care that may require resuscitation • Early warning scores or rapid response team/ medical emergency team criteria/ Red flags • Roles and responsibilities of different healthcare members in the team For APNs Only • Able to distinguish between respiratory distress and failure, utilizing vital signs, clinical exam and supporting tests such as a blood gas • Able to distinguishes between compensated and uncompensated shock based on clinical assessment (stridor, grunting, cyanosis, severe hypo/hypertension, altered mental status etc)
	Skills	Patient care skills reflecting the ability to prioritize and act in rapid sequence, including an assessment, targeted history and physical examination and initiation of emergency treatment. • Conduct rapid assessment of circulation, airway, and breathing (ABC) • Identification of abnormal findings, particularly vital signs in an age-appropriate context • Effective and timely activation of help • Initiate and perform emergency therapy, based on available resources and expertise • Effective communication skills in managing a critical and severely ill patient with acute deterioration
	Attitude	• Respectful towards patients, families and other healthcare team • Make clinical decision/s in accordance to professional standards, scope of practice and level of competence • Uphold professional attributes during patient care • Reflect on practice • Recognise own limitations and seek assistance when necessary
	Experience	Entrusted with relevant small nested EPAs: • Obtain history • Perform physical examination • Prioritize differential diagnoses • Recommend and interpret diagnostic tests • Provide a handover in transfer of care • Formulate, communicate and implement management plans • Present and document a patient encounter in the patient record • Operate equipment / device needed for the procedures • Perform procedures according to scope of practice and level of competence

<table>
<tr><td>Source of information to support summative entrustment decision</td><td>
<table>
<tr><th>Assessment tools</th><th>Number to be completed satisfactorily</th><th>Assessors</th></tr>
<tr><td>Case-based Discussion (CBD) + Entrustment Based-Discussion (EBD)</td><td>At least 1</td><td>Clinical Supervisor
CPP Preceptor</td></tr>
<tr><td>Case Logs</td><td>At least 1</td><td>Clinical Supervisor
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<tr><td>Evaluation</td><td>At least 1</td><td>Clinical Supervisor
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</td></tr>
<tr><td>Entrustment / Supervision level expected at which stage of training.
(At the end of supervised practice)</td><td>
<table>
<tr><th>Level</th><th colspan="2">Descriptors</th><th></th></tr>
<tr><td rowspan="3">Level 2</td><td colspan="2">Direct supervision. Pro-active supervision.
The learner is able to carry out the full activity by himself or herself but requires constant guidance / direction. The supervisor is in the room watching and can intervene or take over at any time deemed necessary.</td><td></td></tr>
<tr><td>a.</td><td>PA conducted as a co-activity with supervisor</td><td></td></tr>
<tr><td>b.</td><td>EPA conducted alone, with supervisor in the room; ready to step in as needed</td><td>X</td></tr>
</table>
</td></tr>
<tr><td>Expiration date</td><td>At least 1 year of non-clinical practice will require re-entrustment and fulfilment of recommended assessments</td></tr>
</table>

<table>
<tr><th>Title</th><th>EPA 4 (Core EPA for APNs, Additional EPA for Pharmacists): Managing care transitions between healthcare professionals and/or settings</th></tr>
<tr><td>Specifications and limitations</td><td>
This activity includes all key activities required of a CPP in handing off patients from encounter to encounter, transitioning or discharging care across settings. It can be performed in various health and social care settings such as hospitals and community.

This activity contains the following elements:
1) Assess indication for transition of care within and/or between healthcare settings and patient transition readiness
2) Discuss and communicate with patient, family, healthcare team members and/or community partners on transition of care
3) Develop a plan for care transition in accordance with patient's care needs, goals and preferences
4) Initiate appropriate referrals and handovers to care team
5) Provide information, education and training required for continuity of care
6) Recommend, facilitate and provide relevant resources required
7) Arrange and ensure a safe transit when moving a patient between settings
8) Coordinate patient care, provide ongoing support and follow up accordingly
9) Maintain proper documentation of consultation and handover reports of patient's transitional care needs

Limitations: This EPA is applicable to the scope of practice defined in the Collaborative Practice Agreement or its equivalent
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</table>
</td></tr>
</table>

<table>
<tr><td rowspan="3">Required knowledge, skills, attitudes and experience to enable summative entrustment</td><td>Knowledge</td><td>• Knowledge to triage the different patients' needs to be managed at the different care settings
• Resources available within inpatient, specialist outpatient and community care settings
• Process to initiate appropriate referrals to various healthcare professionals and/ or care settings
• Process of coordination and follow up on transition of care
• Roles and responsibilities of different stakeholders directly or indirectly involved in the transition of care</td></tr>
<tr><td>Skills</td><td>• Clinical reasoning and decision-making skills
• Effective interpersonal and communication skills
• Care coordination and case management skills
• Clinical documentation skills</td></tr>
<tr><td>Attitude</td><td>• Respectful towards patients, families and other healthcare team
• Make clinical decision/s in accordance to professional standards, scope of practice and level of competence
• Uphold professional attributes during patient care
• Reflect on practice
• Recognise own limitations and seek assistance when necessary</td></tr>
<tr><td></td><td>Experience</td><td>Entrusted with relevant small nested EPAs:
• Provide a handover in transition of care
• Formulate, communicate and implement management plans
• Present and document a patient encounter in the patient record</td></tr>
<tr><td>Source of information to support summative entrustment decision</td><td colspan="2"><table><tr><th>Assessment tools</th><th>Number to be completed satisfactorily</th><th>Assessors</th></tr><tr><td>Case-based Discussion (CBD) + Entrustment Based-Discussion (EBD)</td><td>At least 1</td><td>Clinical Supervisor
CPP Preceptor</td></tr><tr><td>Case Logs</td><td>At least 1</td><td>Clinical Supervisor
CPP Preceptor</td></tr><tr><td>Evaluation</td><td>At least 1</td><td>Clinical Supervisor
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</table>

<table>
<tr><th>Title</th><th>EPA 5 (Core EPA for APNs, Core EPA 2 for Pharmacists): Collaborate with patients, families and community to improve health through disease prevention and health promotion</th></tr>
<tr><td rowspan="2">Specifications and limitations</td><td>This activity includes all key activities which a CPP needs to perform for patients who require health screening, and promotion. It can be performed in various healthcare settings including hospitals and the community.

This activity contains the following elements:

1) Recommend appropriate health screening services that are tailored to individual health concerns, age, risk factors, medical and family history

2) Develop plan of care with individual / their families to address their health problems and goals in a manner that reflects their needs, values, preferences and responsibility in controlling them.

3) Provide patients and their families with information and education that will enable them to improve health, make healthy life choices, assume self-care and cope with acute/chronic illnesses.

4) Refer individuals and/or families to other healthcare professionals and/or community resources where appropriate.

5) Discuss follow-up plans with patients, their families and the healthcare team</td></tr>
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</table>

Required knowledge, skills, attitudes and experience to enable summative entrustment	**Knowledge**	• Common health conditions, including symptoms preceding and of disease, disease trajectory, risk factors for disease and methods to modify risk • Modifiable and non-modifiable determinants of health, risk factors and health behaviours (including stages of behavioural change) • Interpretation of screening tools and test results • Health promotion and disease prevention • Healthy life choices (including diet, lifestyle, and etc) • Available community resources • Process to initiate appropriate referrals to various healthcare professionals and/or care settings • Anticipatory guidance around disease prevention and health promotion For APNs Only • Evidence based guidelines on available age-appropriate health screening tools/tests, including risks, benefits, costs, alternatives of screening, common fears and misconceptions.
	Skills	• In-depth history taking skills • Recognition of abnormalities in growth, developmental milestones, and/or puberty • Clinical reasoning and decision-making skills • Recognition of cases and situations to refer to / involve other healthcare professionals and colleagues • Effective interpersonal and communication skills • Motivational interviewing / facilitation skills • Demonstrates effective health education, teaching, coaching and counselling of patients and families when providing anticipatory guidanceClinical documentation skills and organization skills For APNs Only • Advanced comprehensive health assessment (mental, physical and social) and re-assessment
	Attitude	• Respectful towards patients, families and other healthcare team • Make clinical decision/s in accordance to professional standards, scope of practice and level of competence • Uphold professional attributes during patient care • Reflect on practice • Recognise own limitations and seek assistance when necessary
	Experience	Entrusted with relevant small nested EPAs: • Obtain history • Perform physical examination • Formulate, communicate and implement management plans • Present and document a patient encounter in the patient record • Engage patient/family in in health promotion and disease prevention through education

Source of information to support summative entrustment decision

Assessment tools	Number to be completed satisfactorily	Assessors
Mini-CEX + Entrustment Based-Discussion (EBD)	At least 1	Clinical Supervisor CPP Preceptor
Case Logs	At least 1	Clinical Supervisor CPP Preceptor
Evaluation	At least 1	Clinical Supervisor CPP Preceptor

Entrustment / Supervision level expected at which stage of training. (At the end of supervised practice)

Level	Descriptors		
Level 3	**Indirect supervision. Supervisor is available for reactive/on-demand supervision.** The learner demonstrates independence in carrying out the full activity by himself or herself, but requires intermittent guidance / direction.		
	a.	All findings / decisions double checked	**X**
	b.	Key findings / decisions double checked	
	c.	Findings / decisions discussed on learner's request	

Expiration date

At least 1 year of non-clinical practice will require re-entrustment and fulfilment of recommended assessments

EPAs for Paediatric Collaborative Prescribing

Title	Additional EPA (for APNs and Pharmacist) Identifying, diagnosing and managing children with behavioural and developmental concerns
Specifications and limitations	This activity includes all key activities which a CPP needs to perform whenever a patient is admitted or present with paediatric conditions. This activity contains the following elements: 1) Gather history on patient's behaviour and development milestones and concerns. 2) Recognize common behavioural and mental health issues. 3) Perform developmental assessment and establish developmental stage 4) Recognize abnormal milestones, developmental delays and learning disabilities 5) Interpret findings and propose differential diagnosis. 6) Formulate a management plan 7) Escalate care to senior and/or relevant members of the health care team and follow up accordingly 8) Initiate referrals to medical specialists as appropriate 9) Manage/coordinate patient's needs through appropriate mental health resources available (early intervention programmes, mental health professionals, community social services, support groups, school counsellors, dieticians, physical therapists, occupational therapists etc) to optimize patient care. 10) Communicate with patients and parents about their concerns about the patient's development 11) Document clinical encounter in the patient record
	Limitations: This EPA is applicable to the scope of practice defined in the Collaborative Practice Agreement or its equivalent
Sub-competencies relevant to this EPA	Full description of sub-competencies is found at end of this document

Sub-competency category	Applicable sub-competencies
Patient care ("PC")	PC1, PC2, PC3
Medical knowledge ("MK")	MK1, MK2
System-Based Practice ("SBP")	SBP1
Practice-Based Learning and Improvement ("PBLI")	PBLI1
Professionalism ("P")	P1, P2, P3
Interpersonal and Communication Skills ("ICS")	ICS1, ICS2, ICS3

Required knowledge, skills, attitudes and experience to enable summative entrustment	**Knowledge**	• Anatomy and physiology, Advanced pathophysiology, Advanced pharmacotherapy and applied therapeutics • Age-specific developmental milestones (domains: fine and gross motor, expressive and receptive language, social-emotional, cognitive) • Common developmental, behavioural, and mental health problems in children and adolescents • Normal variants of abnormal behaviour and development in the child and adolescent • Early warning signs of developmental regression or delay. Red flags. • Diagnostic criteria for common behavioural and mental health diagnoses, including current appropriate and validated screening instruments to assess for developmental, behavioural or mental health concerns • Key community services, school services and mental health resources to support coordinated therapies • Escalation and referral processes
	Skills	• Focused health assessment (physical, mental, behavioral, social and developmental) for patients presenting for scheduled well visits or acute concerns • Clinical reasoning and decision-making skills • Effective interpersonal and communication skills • Care coordination and case management skills • Clinical documentation skills
	Attitude	• Respectful towards patients, families and other healthcare team • Make clinical decision/s in accordance to professional standards, scope of practice and level of competence • Uphold professional attributes during patient care • Reflect on practice • Recognise own limitations and seek assistance when necessary
	Experience	Entrusted with relevant small nested EPAs: • Obtain history • Perform physical examination • Prioritize differential diagnoses • Formulate, communicate and implement management plans • Present and document a patient encounter in the patient record

Source of information to support summative entrustment decision	**Assessment tools** / **Number to be completed satisfactorily** / **Assessors** Mini-CEX + Entrustment Based-Discussion (EBD) / At least 1 / Clinical Supervisor CPP Preceptor Case Logs / At least 1 / Clinical Supervisor CPP Preceptor Evaluation / At least 1 / Clinical Supervisor CPP Preceptor
Entrustment / Supervision level expected at which stage of training. (At the end of supervised practice)	**Level** / **Descriptors** Level 3 — **Indirect supervision. Supervisor is available for reactive/on-demand supervision.** The learner demonstrates independence in carrying out the full activity by himself or herself, but requires intermittent guidance / direction. a. All findings / decisions double checked — **X** b. Key findings / decisions double checked c. Findings / decisions discussed on learner's request
Expiration date	At least 1 year of non-clinical practice will require re-entrustment and fulfilment of recommended assessments

Title	**Additional EPA (for APNs and Pharmacists) Assisting in the procedures in the management of critically and severely ill children**
Specifications and limitations	This activity includes all key activities which a CPP needs to perform when assessing, managing, or reviewing care for a critical or severely ill patient. This activity contains the following elements: 1) Recognize the abnormal physiological changes / vital signs changes in the patient 2) Assess and establish the patient's Airway, Breathing, Circulation, Disability (APNs), Exposure (APNs)(ABCDE) 3) Initiate immediate medical care management, if needed 4) Formulate an initial plan of investigation based on diagnostic hypotheses 5) Assist in resuscitating an ill patient with possible acute decompensation and potential impending systemic failure requiring initiation of medical therapy and / or invasive procedures. 6) Perform procedures according to indications, contraindications, complications and steps required in procedures **Skills** IV Cannulation and Venepuncture / Bag-and-mask airway management Blood Gas / Assist in Endotracheal intubation Blood Cultures / Assist in cardioversion/ Defibrillation Female and Male Catheterisation / Assist in line insertion **Limitations:** This EPA is applicable to the scope of practice defined in the Collaborative Practice Agreement or its equivalent
Sub-competencies relevant to this EPA	Full description of sub-competencies is found at end of this document **Sub-competency category** / **Applicable sub-competencies** Patient care ("PC") / PC1, PC2, PC3 Medical knowledge ("MK") / MK1, MK2 System-Based Practice ("SBP") / SBP1 Practice-Based Learning and Improvement ("PBLI") / PBLI1 Professionalism ("P") / P1, P2, P3 Interpersonal and Communication Skills ("ICS") / ICS1, ICS2, ICS3

Required knowledge, skills, attitudes and experience to enable summative entrustment	**Knowledge**	• Basic airway management; emergent intubation techniques including pharmacologic interventions (neuromuscular blockade, sedation, analgesia); direct laryngoscopy; chronic airway management including tracheostomy and oral or nasal endo-tracheal tube utilization; and the disease processes encountered in the PICU involving the airway, such as croup, epiglottitis, sub-glottic stenosis, foreign body, and post-extubation stridor. • Resuscitation algorithm • Acute paediatric cardiopulmonary resuscitation in accordance with Singapore National Resuscitation Council's Advanced Paediatric Life Support Guidelines or American Heart Association (AHA) Paediatric Advanced Life Support (PALS) guidelines. • Equipment/devices used in the care process • Roles and responsibilities of different healthcare members in the team
	Skills	Resuscitation of a patient with acute decompensation and potential impending systemic failure requiring initiation of medical therapy as well as prescribing or performing invasive procedures. These activities will vary by setting, resources and the expertise of the practitioner/team. • Assist in managing airway compromise • Ability to recognizes difficult airways and escalates care to advanced airway teams when required • Provide respiratory support for respiratory distress and failure (support with oxygen, medications, non-invasive positive pressure, and prescription of initiation of mechanical ventilation as appropriate). • Assist in resuscitation of patients in shock (administer volume, antibiotics, and recognize need for vasoactive medications and secure vascular access whether IO or prescribing central access). • Assist in cases of potential neurologic compromise (administers anti-seizure medications as indicated, imaging studies, airway management, and consultation with critical care and neurosurgery). • Assist in ordering appropriate diagnostic studies as indicated.
	Attitude	• Respectful towards patients, families and other healthcare team • Make clinical decision/s in accordance to professional standards, scope of practice and level of competence • Uphold professional attributes during patient care • Reflect on practice • Recognise own limitations and seek assistance when necessary

<table>
<tr><td>Required knowledge, skills, attitudes and experience to enable summative entrustment</td><td>Experience</td><td>Entrusted with relevant small nested EPAs:
• Provide a handover in transfer of care
• Formulate, communicate and implement management plans
• Present and document a patient encounter in the patient record
• Operate equipment / device needed for the procedures
• Perform procedures according to scope of practice and level of competence</td></tr>
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CPP Preceptor</td></tr></table></td></tr>
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The learner is able to carry out the full activity by himself or herself but requires constant guidance / direction.
The supervisor is in the room watching and can intervene or take over at any time deemed necessary.</td><td></td></tr><tr><td>a.</td><td>PA conducted as a co-activity with supervisor</td><td></td></tr><tr><td>b.</td><td>EPA conducted alone, with supervisor in the room; ready to step in as needed</td><td>X</td></tr></table></td></tr>
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Sub-Competencies

PC	Patient Care
PC1	Gathers and Synthesizes Essential and Accurate Information to Define Each Patient's Clinical Problem(s): • Acquires accurate histories from patients in an efficient, prioritized, and hypothesis-driven fashion • Performs accurate and efficient physical exams that are targeted to the patient's complaints • Synthesizes data to generate a prioritized differential diagnosis and other related medical problems • Effectively uses history and physical examination skills to minimize the need for further diagnostic testing
PC2	Develops and Achieves Comprehensive Management Plan for Each Patient: • Appropriately modifies care plans based on patient's clinical course, additional data, and patient preferences • Manages both acute and chronic medical issues proficiently and takes into consideration their interrelation in development of management plan • Consistently plans for patient's discharge in advance and considers early intervention for barriers to care
PC3	Requesting Referrals and Escalating Care: • Asks specific and relevant questions in a succinct manner when making referrals • Gathers information accurately and completely. Organizes it in a manner which facilitates the referral consultation • Identifies patients who are in distress and/or clinically unstable and informs seniors in a timely manner after attempts to assess patients and institute preliminary measures appropriately.
MK	**Medical Knowledge**
MK1	Clinical Knowledge: • Possesses the scientific, socioeconomic, and behavioral knowledge required to provide holistic patient care for complex medical conditions.
MK2	Knowledge of Diagnostic Testing and Procedures: • Consistently interprets basic and advanced diagnostic tests accurately and relates to clinical context • Understands the concepts of pre-test probability and test performance characteristics to be able to choose the best test for the patient • Fully understands the rationale and risks associated with all common tests

EPAs for Paediatric Collaborative Prescribing

Sub-Competencies

SBP	System-Based Practice
SBP1	System Navigation for Patient-Centred Care: • Identifies patients' priorities and values • Requires guidance to relate them to the clinical targets and management plans. Makes attempt to involve patient in care planning • Understands the roles of members within inter-professional teams and leverages on them to achieve clinical targets with reduced supervision • Recommends and utilises resources to return patients to state of health within the community. Requires guidance in seeking patients and family's understanding and acceptance of how
PBLI	**Practice-Based Learning and Improvement**
PBLI1	Evidence-Based and Informed Practice: • Critically appraises and applies evidence even in the face of uncertainty and conflicting evidence to guide care, tailored to the individual patient
P	**Professionalism**
P1	Professional Behavior and Ethical Principles: • Recognizes situations that may trigger professionalism lapses and intervenes to prevent lapses in self and others • Analyzes complex situations using ethical principles and consistently applies them in managing situations of ethical dilemma • Seeks help consistently for complex ethical situations after making preliminary attempts to address issue
P2	Accountability and Conscientiousness: • Takes ownership for all patients assigned to self. Follows through completely on all identified tasks. and ensures complete implementation of orders within care plans • Bears responsibility for gaps by adopting measures to close decision loops. • Considers factors contributing to lapses and how they can be prevented.
P3	Self-Awareness and Help-Seeking • Independently develops a plan to optimize personal and professional well- being • Independently develops a plan to remediate or improve limits in the knowledge/ skills of self

Sub-Competencies

ICS	Interpersonal and Communication Skills
ICS1	Patient- and Family-Centred Communication: • Easily establishes therapeutic relationships, with attention to patient/family concerns and context, regardless of complexity • Independently recognizes personal biases while attempting to proactively minimize communication barriers • Independently uses shared decision making to align patient/family values, goals, and preferences with treatment options to make a personalized care plan
ICS2	Interprofessional and Team Communication: • Listens actively to inputs from members in primary and inter-professional team to understand and appreciate their perspectives • Proactively clarifies when in doubt before forming conclusions • Clear and respectful in communication (including provision of feedback and handling disagreement) with colleagues and superiors
ICS3	Communication within Health Care Systems: • Communicates clearly, concisely, in a timely manner, and in an organized written form, including anticipatory guidance • Produces written or verbal communication (e.g., patient notes, e-mail, etc.) that serves as an example for others to follow • Initiates difficult conversations with appropriate stakeholders to improve the system

Collaborative Prescribing Practices Guidelines

Overarching Practice Statements

The Collaborative Prescribing ("CP") Practitioner is responsible for the care of the patient and should have knowledge and access to patient's most updated clinical records.

The CP Practitioner should:

a. Establish the patient's clinical history, latest investigations and concurrent use of medications.

b. Assess the patient's clinical condition(s).

c. Apply appropriate clinical reasoning to identify the most appropriate treatment options (i.e. pharmacological and non-pharmacological) in partnership with the patient and/or caregiver.

d. Explain and ensure that patient/caregiver understands the treatment plan.

e. Document the treatment plan clearly, accurately, and legibly in a timely manner.

f. Communicate with the patient's physician and/or the multidisciplinary team involved in patient's care whenever necessary.

Guidelines for Communication and Clinical Documentation

Communicating with patients and family members and caregivers

Appropriate education and provision of information to patients about their medications is essential to ensure safe and effective medication use. CP Practitioners should inform patients about their treatment options, indications, risks that include potential adverse effects, and complications; and responsibilities towards an agreed medication management plan.

CP Practitioners should:

a. Provide information on prescribed medicines to patients and caregivers as part of the clinical consultation with documentation of this counseling in the patients' record. Where necessary, printed medication information can be given to patients to enhance understanding.

b. Provide communication channel for patients and/or caregivers to clarify any doubts or concerns; and to report any side effects, so that early medic al attention can be sought.

Good recording practice

All consults with CP Practitioners must be documented either on electronic or handwritten case logs.

a. Electronic case log entries should not be altered, and changes in clinical decisions and prescriptions should be clearly documented as addendums.

b. Handwritten case log entries should be legible and made in ink. Any amendments made should be crossed out with a single line, initialled, dated and time-stamped.

Recording specifications

The documentation should include pertinent discussions with the patient and CP Practitioner, and should include the following when necessary:

a. Date and time of consult.

b. Identifying information, including that of the member documenting the patient contact.

c. Patient's presenting symptoms or concerns (e.g. medication assessment, pharmaceutical opinion, follow-up, etc.).

d. Patient's history summary and care plan if developed. (The record should acknowledge whether a care plan was available. If a care plan is part of the patient record it should be acknowledged in the documentation).

e. Documentation of patient's voluntary and informed or implied consent, or that of their substitute decision maker, if any.

f. Information provided to or received from other caregivers.

g. Collaboration undertaken with other caregivers, including outcomes, and/or proposed courses of action.

h. Assessments, interventions, and recommendations where professional judgment was exercised along with the evidence on which the recommendations are based; and

i. A follow-up plan that is sufficiently detailed to monitor the patient's progress and ensure continuity of care by the CP Practitioner, and other regulated health professionals or caregivers, if applicable.

Collaborative Prescribing Practices Guidelines

Guidelines for CP Prescriptions

Good prescribing practice

All CP Practitioners must have sufficient knowledge of the medications they prescribe; if in doubt, they should check with a senior medical practitioner, pharmacist or check with drug references.

CP Practitioners must not provide care to themselves or those close to them where this involves controlled drugs and drugs with significant potential for dependence or psychiatric care.

The CP Practitioner should indicate the following on an CP prescription:

a. Patient identification
The patient's name, address and identification number should be included on the prescription.

b. CP Practitioner identification
The CP Practitioner's name, employment address and nurse/pharmacist registration number.

c. Date and time of the prescription
The CP prescription should not be back-dated, or signed off in advance.

d. Medication name
Medications prescribed by the CP Practitioner must be written in their non-proprietary names, except for medications in combination, and when patients are allergic to certain excipients (i.e. can only take particular brand(s)).

e. Dosage form
The dosage form and/or route of administration must be clearly stated on the prescription.

f. Dosage regimen
For medications intended to be taken when required (i.e. PRN), the prescriber should state the indications and the number of doses required and/or the total quantity to be dispensed.

g. Duration and/or quantity of medication
For medications where the duration cannot be indicated, the quantity to be prescribed should be clearly stated.

h. Signature and professional registration number of the CP Practitioner
In order to ensure timely review of the patients, the prescriptions should not be written or printed-off and signed in advance. CP Practitioners should issue electronic prescriptions as much as possible, and any amendments should be made to the prescription within 24 hours.

Mode of prescribing

CP Practitioners should issue electronic prescriptions as much as possible. Handwritten prescriptions could be issued when necessary if:

a. The CP Practitioner is on a home care visit, and/or

b. There is a system downtime

Handwritten prescriptions by the CP Practitioner must be written in non-erasable ink and should be written by the same CP Practitioner throughout.

Prescription storage

All original hard copy and electronic prescriptions issued by CP Practitioners should be preserved for a duration required by the Therapeutic Product Regulations for audit and legal purposes.

Prescriptions for Controlled Drugs ("CDs") should be preserved for the duration stipulated in the Misuse of Drugs Regulations.

Non-routine prescribing scenarios

Medication refill

Medication Refill refers to the re-ordering of medications not previously ordered by the CP Practitioner, but in accordance to a previously prescribed medication list for patients under their care without consultation with a medical doctor or a CP Practitioner.

The CP Practitioner should only issue a medication refill if:

a. The quantity of medication prescribed does not match the next appointment date given.
b. Prescriptions or medications have been misplaced.
c. The integrity of the medication has been compromised.
d. Appointment date has been rescheduled to a later date

When issuing a medication refill, the CP Practitioner should:

a. Ensure that the patient:
   i. Is clinically stable.
   ii. Has been taking all the medications at the same dose since the last consult.
   iii. Is on regular follow-up with their doctor (i.e. not more than 1 year).
   iv. Has secured his/her next appointment date with the doctor.
b. Check the patient's latest available and relevant medical record to ensure that the medication and/or its dose has not been adjusted since his/her last visit.
c. Re-order medications that are on the approved drug formulary in the Collaborative Practice Agreement ("CPA").

The duration of medication refilled should not:

a. Exceed the patient's next appointment date.
b. Exceed a 2-week supply if the patient has not made his/her next appointment date.

Prescribing in a home care setting

The CP Practitioner that carries out home care visits should maintain the list of patients under his care and avail the list to members of the same care team. The CP Practitioner should maintain these patient records on the electronic databases of their employed institution, which is subject to a review by a medical doctor(s) of the same care team on a regular basis as stipulated within their individual CPAs.

The CP Practitioner's employed institution must ensure that there is proper inventory management of the medications checked-in and checked-out of their employed institution's medication supply or pharmacy, which must be regularly audited by the person-in-charge of the medication supply or a registered pharmacist at least once every 3 months.

The inventory documentation must include the following information:

a. Name of CP Practitioner.
b. Professional Registration number of CP Practitioner.
c. Date and time of check-in and check-out of medications.
d. Medications (i.e. name, dosage form, quantity, strength and batch number).
e. Expiration date of the medication

The following non-exhaustive list of potential work processes are provided as examples to guide the development of the institution's policies and processes:

a. The CP Practitioner should avoid playing the role of the prescriber, dispenser and administrator concurrently in a home environment. Suitable processes should be in place to allow a second suitably competent person e.g. Registered Nurse, Registered Pharmacist or Physician to check the medications dispensed before administration to the patient by the CP Practitioner.

b. The CP Practitioner should return all medications brought out for home care visits back to their institutions at the end of the work day. All drugs shall be stored within the institution's pharmacy or medication storage area. In case of exigencies where medications could not be returned at the end of the day, the institution shall have policies and procedures to define the exigencies and ensure that the drugs are kept appropriately and securely, and the drugs are returned to the institution within 3 working days for reconciliation.

Collaborative Prescribing Practices Guidelines

Examples of work processes for additional safeguards for CDs in home care setting:

a. Institutions that intend to implement CP services which involve the use of CDs must have institutional guidelines and SOPs in place that govern the use of CDs. The guidelines and SOPs must minimally address the following:
   i. The CP Practitioner should avoid playing the role of the prescriber, dispenser and administrator concurrently in a home environment. Suitable processes should be in place to allow a second suitably competent person e.g. Registered Nurse, Registered Pharmacist or Physician to check the medications dispensed before administration to the patient by the CP Practitioner.
   ii. Institutions should set guidelines on the quantity and type of controlled drugs brought by CP Practitioners during home care visits, taking into account the average number of patient visits each CP Practitioner makes in one day, the CD requirement profile of the case mix, safety and other operational considerations. CP Practitioners should only carry emergency or interim stocks for immediate supply to the patient and for long term needs, a prescription should be provided to the patient for the CD to be filled by at a pharmacy.
   iii. A situation is an emergency if the patient is experiencing uncontrolled pain and other symptoms such as dyspnea that are relieved by opioids. CP Practitioner to supply only if the patient does not have the required opioids in his/her existing stock of medications.
   iv. Institutions should set guidelines on the quantity and duration of controlled drugs supplied by CP Practitioner for emergency doses or for interim supplies, which should not exceed a maximum of three-day supply, so that patient has a supply of CDs until the patient or their caregiver can fill their CD prescriptions.
   v. Institutions should set guidelines on the type of personnel that are authorised to transport CDs, and the safeguards to prevent loss, theft, and diversion of CDs during transport.
   vi. CDs should always be transported by authorized personnel e.g. Registered nurses, physicians and kept by the staff and under lock and key.
   vii. CP Practitioners shall maintain a register to record the actual CD dispensing in accordance with the Misuse of Drugs Regulations.

b. If a patient/client has a history of drug abuse or is suspected of drug abuse or exhibits drug seeking behaviour the CP Practitioner should refer the case to his/her collaborating doctor.

c. Parenteral CDs must be prepared and supplied by a suitably competent healthcare professional e.g. registered nurse, physician according to the prescribed doses for the purpose of administration. Lay caregivers must not be empowered to prepare parenteral CDs for the patients.

d. CP Practitioner must educate the patient/client on the indications, method of administration, the side effects and their managements, proper storage and disposal of the CDs.

Risk Management

The aim of risk management is to:
a. Ensure patient safety through the minimization of risk associated with the inappropriate use of any prescription medication, and
b. Improve the quality of the collaborative prescribing system.

Risk mitigation

The section details the possible scenarios where risk mitigation would be useful.

a. Prescribing rights
   i. CP Practitioners should only prescribe when they have been privileged. When e-prescribing systems are in place, the CP Practitioners should be granted the rights to prescribe only after privileging has been approved.

b. Prescribing within the scope of the CPA
   i. CP Practitioner should verify that the medication prescribed is within the approved medication list.
   ii. The approved medication list should be made easily available to all healthcare professionals employed within the institution.

c . i. Prescribing during system downtime
   CP Practitioners should manually obtain clinical history, including medications and possible allergies, from the patient and/or caregiver.
   ii. Written prescriptions issued should be retrospectively documented on the electronic system.
   iii. CP Practitioners should review his/her prescriptions against the patients' clinical history once the system has been restored.
   iv. When in doubt or when the risk of error is high, and if the situation is non-urgent, the prescription should be delayed until the necessary verification can be conducted.

Medication safety

The following are recommendations to ensure medication safety when prescribing.

a. Electronic medication ordering and clinical decision support system should be utilized, where possible.
b. Routine checking of latest available patient records prior to and/or during each consult.
c. Clear communication with the patient and/or their caregivers to obtain a full clinical history.
d. Patient and/or caregiver are provided with a channel for feedback or advice in the event of an adverse reaction or medication incident.
e. Proper documentation of patient's consultation.
f. Where errors and adverse events have been detected, the patient should be reviewed at the earliest possible opportunity.
g. Training on medication safety and on-going education of CP Practitioner should be provided regularly.

Incidents and Complaints Reporting Management System

Whistleblowing

Whistleblowing is important to patient safety, but is often avoided for fear of being in the vanguard of change. This section details the various aspects of whistleblowing and the appropriate reporting channels.

Protection for whistle-blowers
An employer shall not penalise or threaten to penalise an employee or cause or permit any other person to penalise an employee, for having made a disclosure.

Types of incidents reported include:
a. Unfair judgement of CP Practitioner's clinical practice resulting in unjust treatment of CP Practitioner (e.g. dismissal of CP Practitioner).
b. Failure to provide adequate information of medication to patient where significant risks are present.
c. Failure to report suspected drug addicts to the Director-General of Health ("DGH") and Director of Central Narcotics Bureau.
d. Irresponsible or injudicious prescribing, in particular a substance of potential abuse.
e. Malpractice such as prescribing for relatives without proper medical consultation.
f. Exceptional failure such as fatal medication error.
g. Anticipation of potential catastrophic error/event.

Disclosure on fellow colleagues should be made
a. In good faith without any malice.
b. Where there is reasonable belief that the information is substantially true.Where
c. there is no intended personal gain.
d. Where it is reasonable considering the circumstances.

Collaborative Prescribing Clinical Governance Guidelines

Introduction

This guidance sets out procedural steps to empower selected Advanced Practice Nurses and Pharmacists with prescribing responsibilities.

Aims of Collaborative Prescribing

The aims of extending prescribing responsibilities to our selected Advanced Practice Nurses and Pharmacists are to:

a. Improve patient's accessibility to care;
b. Provide quality care without compromising patient safety;
c. Increase patient choice in accessing medicines; and
d. Enable better use of their expertise.

Definitions

Collaborative Prescribing Practitioner means a pharmacist or registered nurse who is approved by the Credentialing Committee under regulation 6(1)(a) of the Healthcare Services (Collaborative Prescribing Service) Regulation.

a. Credentialing is the formal process of reviewing, verifying and evaluating a professional's credentials (i.e. education, training, experience, certification, licensure and other professional qualifications) to ensure that they are sufficiently competent to be awarded clinical privileges to practice within an approved scope of practice.

b. Privileging is the process of determining each professional's level of competence to carry out specific diagnostic, treatment procedures and prescribing. It focuses on the individual's current skills and competence. Clinical privileges are granted when professionals are assessed to be qualified to perform the specific service/procedure required.

Collaborative Practice Agreement ("CPA") means an agreement for and relating to the provision of a collaborative prescribing service by a collaborative prescribing practitioner for and on behalf of a licensee.

a. The CPA should specify the site(s) in which the CP Practitioner(s) is practicing. This agreement would delineate the CP Practitioner's scope of practice and should include the following:
    i. Medical conditions and/or defined patient groups.
    ii. Drug Formulary (excluding clinical trial drugs).
    iii. Clinical Decisions.
    iv. Tests and Investigations.
    v. Escalation Criteria.
    vi. Patient Exclusion Criteria.

Prescriptions written and signed off by a CP Practitioner authorises a patient to be issued a medication or treatment as defined in their Collaborative Practice Agreement, which can be filled at any licensed facility or pharmacy in Singapore.

Roles and responsibilities of the CP Practitioner

Accountability

CP Practitioners are accountable for all aspects of their prescribing decisions including initiation, titration and discontinuation of medications, and are not permitted to delegate this accountability to any other person.

They must be able to ensure that the:

a. Medicines prescribed are safe and effective for the patient under their care and the condition being treated;
b. Potential influence from the patients, colleagues and pharmaceutical industry that may result in inappropriate prescribing are recognised and managed; and
c. Choice of medicinal product for the patient is made based on clinical suitability and cost effectiveness.

CP Practitioners should only see patients on first visit as part of a care team led by a medical practitioner within the ambit of a CPA.

CP Practitioner should avoid playing the role of the prescriber, dispenser and administrator concurrently.

CP Practitioner should remain up-to-date with the knowledge and skills required for safe prescribing practice.

Roles and responsibilities of the Collaborating Medical Practitioner

Collaborating medical practitioners are held accountable for the scope of practice of the CP Practitioner as indicated in the Collaborative Practice agreement, and must ensure that:

a. All acts of prescriptive authority are document and utilised in a manner that is consistent with any rules and conditions imposed upon the CP service;
b. They are available for consultation or assistance, as required by the CP Practitioners; and
c. The CP Practitioners have avenues to review and improve on their service, when necessary.

The Collaborative medical practitioner can delegate his/her supervisory duties to medical practitioners within the same care team.

Roles and responsibilities of the Employing institution

CP services within employing institution

The employing institution is held vicariously responsible for the CP Practitioners, who are permitted to prescribe as part of their professional duties with the institution's consent.

The CP Practitioner should not be the prescriber, reviewer, and dispenser for the same patient at the same visit. Under circumstances where the CP Practitioner has to take on multiple roles, a second suitable competent person (i.e. registered nurse, medical doctor, pharmacist) should be involved in the checking process.

CP services with external institution

For CP services provided by the CP Practitioner to an external healthcare institution, as agreed upon by the employing institution, a service contract which details the accountability of each institution is required in addition to a CPA.

Scope of practice in collaborative services

a. The CP Practitioner and the medical practitioner's (who may be employed by the external institution) scope of practice and specifically parameters of prescribing must be clearly defined in the CPA. The following should be considered when drafting the CPA:
    i. The prescriber's professional competency in the area of practice.
    ii. Ability to value add to current service.

Practice framework

a. Clinical governance - The services of a CP Practitioner can be contracted by institutions with differing operational structure and clinical governance systems, as such arrangements must be in place to audit practices and safeguard the patients under their care.

b. Support and escalation – The employer of the CP Practitioner and the collaborating institutions must ensure that there are adequate support mechanisms, resources, and escalation processes to support and guide the CP Practitioner's practice for the contracted services.

Dispute resolution (i.e. Prescribing conflicts)

Institutions involved should include measures in the service agreement to resolve disputes (e.g. differing opinions involving course of treatment).

Institutional Collaborative Prescribing Governance

Medical Practitioner-in-charge (CP)

The Medical Practitioner-in-charge ("MPIC") of CP services should

a. Fulfil the following eligibility criteria
   i. Be a Registered medical practitioner
   ii. Is the medical director, or a member of the medical board or clinical board, of the licensee;
   iii. Has not, in the period of 3 years before the medical practitioner's employment or engagement by the licensee, been the subject of any order made by a Disciplinary Tribunal under section 59D(2) or 59E of the Medical Registration Act 1997.
b. Oversee the provision of the CP service by the licensee to ensure that it is provided in a proper, effective and safe manner.
c. Consider the findings of the Service Review Committee in respect of the provision of any CP service by the licensee and ensure that necessary measures are implemented to address any issue raised by the Service Review Committee.
d. Where the MPIC is satisfied that a CP service by any CP Practitioner has not been provided in a proper, effective and safe manner, to make a recommendation for the cessation of the CP service by that CP Practitioner and provide the licensee with his or her reasons for the recommendation.

Credentialing Committee

The functions of the Credentialing Committee ("CC") with respect to CP Practitioners are to:

a. Approve as a CP Practitioner every pharmacist or registered nurse who meets the eligibility criteria defined in the Healthcare Services (Collaborative Prescribing Service) Regulations 2023 , and through whom the licensee provides or intends to provide any CP service.
b. Approve the Collaborative Practice Agreement ("CPA") entered into by every CP Practitioner, before the agreement is implemented in relation to the provision of any CP service.
c Consider the findings of the service review committee in respect of the provision of any CP service by the licensee to determine whether the provision of CP service by every CP Practitioner for and on behalf of the licensee is in accordance with his or her CPA.
d. Review every CPA at least once every 3 years commencing after the date of that agreement, for the purpose of ensuring that the information and provisions in the CPA remain relevant and correct.

The CC will consist of a minimum number of 3 members, which shall include a medical practitioner, and all the remaining members of the CC shall fall within one or more of the following categories of persons:

a. Where the licensee is required to appoint a quality assurance committee under regulation 20 of the Healthcare Services (General) Regulations 2021 – at least one must be a member of the licensee's quality assurance committee.
b. Where one or more of the licensee's personnel are CP Practitioners – at least one must be a CP Practitioner.

The Chair of the CC must be a medical practitioner who has the necessary qualifications, experience, competency and skills to oversee the carrying out of the CC's functions, and be appointed by the licensee. The term of office of the members of the Credentialing Committee shall be determined by the Chairman Medical Board or equivalent.

Collaborative Prescribing Clinical Governance Guidelines

Collaborative Prescriber Lead

The profession-specific CP Lead(s) will be appointed by the MPIC, with recommendations from the Nursing, Pharmacy, and/or Allied Health Head of Departments, and their roles are to:

a. Communicate: To convey relevant national CP updates to their employed institutions.
b. Advocate: Identify and review areas of service needs where CP can improve the quality of care and/or improve clinical workflow.
c. Coordinate: Identify and collaborate with the designated medical practitioner for Advanced Practice Nurses and Pharmacists enrolled in the CP training programme, and ensure the sustainability of the CP services.
d. Clinical governance: Ensure that the CP Practitioners maintain and update their personal competency portfolio.
e. Support: Serve as a mentor to the CP Practitioners.

Service Review Committee

Every institution that sets up CP services must appoint a CP Service Review Committee ("SRC"). The functions of the committee are to:

a. Monitor and review the quality and effectiveness, including conducting audits, of the CP service provided by the licensee.
b. Report the findings of its audit and review to the licensee's MPIC and CC.
c. Oversee the implementation of, and compliance with, all the CPAs entered into by all the CP Practitioners through whom the licensee provides any CP service.
d. Identify trends and patterns that do not comply with the policies, processes, procedures and protocols implemented by the licensee in respect of the provision of CP service, and to conduct further investigations into whether any inappropriate care or unsafe treatment has been provided to any patient.
e. Make recommendations to the licensee on the management and resolution of any problem which arises in connection with any CP service provided by the licensee, and to assess the effectiveness of the recommendations that are implemented by the licensee.
f. Pursue opportunities for the improvement of the provision of any CP service by the licensee.
g. Conduct regular review of the monitoring and outcome indicators set by the licensee in respect of any CP service and to report the findings of the review to the MPIC and the CC.

The committee will consist of a minimum number of 5 members, which shall include a medical practitioner, and all the remaining members of the SRC shall fall within one or more of the following categories of persons:

a. Where the licensee is required to appoint a quality assurance committee under regulation 20 of the Healthcare Services (General) Regulations 2021 – a CP Practitioner or a member of the licensee's quality assurance committee.
b. In any other case – a CP Practitioner or a healthcare professional.

The Chair of the SRC must be a healthcare professional who has the necessary qualifications, experience, competency and skills to oversee the carrying out of the SRC's functions and be appointed by the licensee.

Credentialing Process

Pre-requisites for CP service application

A service need must first be identified by the Head of Department where a CP Practitioner prescribing will improve the clinical workflow. Thereafter, the clinical head(s) of department identifies the suitable Advanced Practice Nurse(s) and/or Pharmacist(s) suitable to provide the service. The identified APN and/or Pharmacist can then proceed to register for the CP training programme with a Letter of Support from their respective Heads of Department endorsed by their collaborating medical practitioner and the MPIC.

Upon completion of the CP training programme, the Advanced Practice Nurse or Pharmacist should enter into a Collaborative Practice Agreement ("CPA") with a medical doctor(s) within 2 years. The CPA must subsequently be reviewed and approved by a CC, before the CP Practitioner is awarded the clinical privilege to prescribe. The Advanced Practice Nurse or Pharmacist can then submit their CP certification and CPA to the Ministry of Health ("MOH") to be entered into the list of CP Practitioners that is published on the MOH's Healthcare Professionals Portal.

Review of Collaborative Practice Agreements

The CPA must be reviewed once every 3 years and may be amended in writing and signed by all parties.

For each CP service, the CP Practitioner should submit monitoring indicators to the respective institutional professional designates for tracking and audit purposes. These could include the following:

a. Safety (e.g. number of errors/near misses, number of CPA deviations, number of ADRs reported) [Compulsory].
b. Process (e.g. number of patients prescribed under CPA).
c. Outcome (e.g. time within therapeutic range, number of bleeding events, number of disease flares).
d. Quality (e.g. patient satisfaction).

The respective Heads of Department must prepare a performance report regularly (not less than 3 yearly) detailing the various submitted indicators, gaps and deficiencies identified, and proposed improvement plan (within 6 months) to bridge gaps and deficiencies identified. This report should be submitted to the institution's SRC for review and audit.

Collaborative Prescribing Clinical Governance Guidelines

Ad-hoc review of Collaborative Practice Agreements

For changes that need to be made prior to the scheduled review of the Collaborative Practice Agreements, the CP Practitioner should seek approval and inform the respective parties.

CP Practitioners must seek approval from the CC for the following changes to the CPA:

a. Changes in partnering institutions for collaborative services.
b. Changes to the scope of practice (e.g. change in list of medical conditions, addition of new procedures).
c. Changes to the escalation criteria to medical doctors.
d. Inclusion of new prescription-only-medicines to the drug formulary.

CP Practitioners can seek endorsement from their Head of Pharmacy Department and/or Director of Nursing before seeking approval from the CC for the following changes to the CPA:

a. Changes to the department of practice.
b. Change to the clinical team and signatories.
c. Inclusion of new general sales list medications and pharmacy-only medications to the drug formulary.
d. Inclusion of new investigations and tests.

The Ministry of Health should be informed of changes to the CPA (e.g. change practitioners, scope of formulary, supervisors or drug formulary). This can be done by submitting the Notification Form for Planned Changes to a Collaborative Prescribing Service and the updated CPA to hcsa_enquiries@moh.gov.sg. The licensee should refer to the Ministry of Health website, for the list of changes to the CPA that are reportable.

Disciplinary Management

Complaints and disciplinary actions against CP Practitioners

Any complaint of a CP Practitioner should be submitted to the SRC for review in writing, and can consist of:

a. Improper conduct of a CP Practitioner which brings disrepute to his/her profession;
b. Information on the conviction of a registered CP Practitioner of any offence implying a defect in character which makes him unfit to practise as a CP Practitioner;
c. Professional services provided by a CP Practitioner are substandard; or
d. Information that indicates that the CP Practitioner is physically or mentally unfit to practice.

Any wilful acts of disregard for approved CPA and policies and procedures should be escalated by the SRC to the MPIC. The MPIC shall inform the relevant authorities in the event of the scenarios listed below.

Professional Boards

a. Act of negligence.
b. Professional misconduct.
c. Action that causes or would cause harm to the patient.

Health Sciences Authority

Any medication prescribed by the CP Practitioner that is not on their approved medication list as stated in the CPA.

Incident reporting

All errors, near misses, and deviations from the CPA should be:

a. Reported in institutional risk management system as per institutional policy.
b. Submitted to the SRC within 48 hours.

All errors that had resulted in any form of harm will require a root cause analysis to be conducted by the institutional medication safety committee or equivalent. The results of the investigation and the recommended course of action shall then be routed to the SRC for review.

Suspension of services provided by CP Practitioners

This section refers to the suspension of CP service in a particular service area if the review of the SRC reveal:

a. Significant number of adverse drug events as decided by SRC.
b. Negligent prescribing outside the list of approved medications.
c. Negligent prescribing/consultation for patients not registered with the CP service.
d. Unauthorized delegation of prescribing.
e. Any other deviations from the CPA, as determined by the SRC that may compromise patients' safety and welfare or bring disrepute to the profession.

The service may be suspended for the duration of investigations by the licensee. The MPIC must be notified of all suspensions and outcomes of the investigations.

The continuation of the CP service after the investigation has been completed would be subject to the SRC's findings and licensee's decision. MOH must be informed should there be a need for all CP services within the institution to be suspended.

Collaborative Prescribing Clinical Governance Guidelines

Suspension of CP Practitioners

The following situations may warrant an investigation by the SRC and result in suspension of the CP Practitioner:

a. Failure to renew CP privilege and CPA.
b. Significant number of adverse drug events as decided by SRC.
c. Wilful prescribing outside the list of approved medications.
d. Wilful prescribing/consultation for patients not registered with the CP service.
e. Unauthorized delegation of prescribing.
f. Any other situations deviations from the CPA, as determined by the SRC that may compromise patients' safety and welfare.

The CP Practitioner's right to prescribe may be withheld by the institution pending investigation by the SRC. The CP Practitioner will be notified of their suspension in writing by the CC.

The CP Practitioner should not prescribe during the investigation period, and any non-compliance will be escalated to the respective professional boards and HSA. The CP Practitioner's prescribing rights will be restored by the licensee only after the investigation has been completed, subject to the SRC's findings and the licensee's decision.

Appeal System

The CP Practitioner whose credentials have been denied or terminated has the right to appeal against the decision of the CC.

Appeals shall be made to the CC within 30 days of receipt of notification that the clinical privileges have not been granted or terminated. The appellant should attach to his/her letter of request for appeal relevant documentation such as a logbook that details the training courses attended, number of hours of hands-on experience, appropriate endorsement by renowned authorities and other relevant information to support his/her case.

The CC will reply within 14 days after receipt of all relevant documents and if the appellant is not satisfied with this outcome, he/she may then submit a final appeal to the institution's Chairman Medical Board or equivalent within the next 14 days.

The Chairman Medical Board or equivalent will appoint a panel (3 or more members) with no conflict of interest, minimally comprising a doctor, a pharmacist CP Practitioner, and/or a nursing CP Practitioner to review the appeal application. The panel will meet within 21 days of receiving the appointment letter to review the application. Information and opinion may be sought from external institutions if required. The CC will present the case to the institution's appeals panel. The panel may also conduct an interview with the appellant and the respective Heads of Department, and other involved parties to seek clarifications and identify their concerns if necessary.

The panel should submit a report on their final decision and recommendations to Chairman Medical Board within 60 days from the review commencement date.

A letter will be given to the appellant on the outcome of his/her appeal, with the reasons clearly stated if his/her appeal is rejected. The CP Standing Committee, Medical Board, MPIC, SRC, and CC will be kept informed of the final outcome of the appeal.

Maintenance of Competency for CP Practitioners

CP Competency Portfolio for CP Practitioners in active practice

The CP lead should ensure that the CP Practitioner maintains a competency portfolio for maintenance of competency purposes. For new CP Practitioners starting their practice or existing CP Practitioners starting a new scope of CP practice, for the first 2 years of their practice, the portfolio should consist minimally of:

a. Collaborative Practice Agreement.
b. 4 Prescribing logs per year (please refer to Annex A for the template).
c. Continuing Professional Education ("CPE") log specific to area of CP practice (please refer to Annex B for the template).
d. CPE requirements of their respective professional boards, but at least 30% of the CPE should be related to the area of CP practice.
e. Clinical supervision where applicable.
f. Minimum clinical practice requirement of issuing 10 prescriptions a year.

For CP practitioners after 2 years of active CP practice within the same scope, the competency portfolio would then be revised to consist minimally of:

a. Collaborative Practice Agreement.
b. CPE requirements of their respective professional boards, but at least 30% of the CPE should be related to the area of CP practice.
c. Clinical supervision where applicable.
d. Minimum clinical practice requirement of issuing 10 prescriptions a year.
e. Attend at least one healthcare institution internal peer sharing sessions for continuous learning yearly, related to the area of CP practice. The internal peer sharing session, either inter- or intra-profession, and related standards must be approved by the chairman of the SRC and overseen by the MPIC.

CP Practitioners with more than 2 years of active CP practice but are entering a new scope of CP practice would be required to follow the maintenance of competency requirements as a newly registered CP Practitioner

The CP Practitioner should be re-credentialed together with a review of his CPA once every 3 years to ensure the CP Practitioners continue to remain relevant and up-to-date with respect to his scope of practice.

CP Practitioners who meet any of the 3 criteria below, will be required to adopt the MOC requirements of a newly registered CP Practitioner and they will have to successfully pass the assessments in the core CP Entrustable Professional Activities ("EPAs") organised by their CC before they are reinstated as CPPs.

a. Do not meet the maintenance of competency requirements
b. Returning to practice after more than 2 years of absence, or
c. Graduated from the CP training programme but did not enter into a CP service within 2 years

Collaborative Prescribing Clinical Governance Guidelines

Annex A

Prescribing Log (Example)

CP Practitioners will be expected to complete at least 4 prescribing logs on an annual basis to be included into their CP Competency Portfolio. Patient data must be anonymized to maintain confidentiality.

Signs and Symptoms (including Patient Medical History, medications, clinical examination and findings, allergies)	**Post assessment diagnosis**	**Treatment plan** (drug name, dosage form, dose, frequency, amount)	**Advice, Referral/ Review, Outcome**	**Reflections and Learning points**
Presenting complaint Hypertension Review. Chronic dry cough after taking Enalapril **Past medical history** Hypertension Type 2 Diabetes on lifestyle management Smoker 20 sticks per day LDL Cholesterol 4.3mmol/L **Examination** BP 160/90mmHg BMI 27kg/m2 **Current medication** (including OTC, Herbal, Internet)(must include dosage strength and be linked to PMH). Enalapril 5mg BD (not regular 4 weeks) **Allergies** None known	Adverse reaction to Enalapril BP remains elevated	Losartan 50mg OM x 28 days	**Advice** 50 year Chinese male Overweight with Type 2 Diabetes - Weight management & lifestyle modification Moderate smoker - Smoking cessation advice **Referral/Review** Review in 2/52 for repeat BP check and renal panel Discussed referral to smoking-cessation clinic- patient not ready at moment **Patient outcome** Patient has high atherosclerotic cardiovascular risk Review lifestyle modification and smoking status at future appointment Review response to losartan and check renal panel To consider initiation of statins if LDL cholesterol still elevated	Use of Enalapril is associated with potential side effect of cough and substitution with another class of renin-angiotensin-system blockade agents may be needed. Patient should be forewarned. Patient may not always be ready for change in a particular lifestyle habit (i.e. smoking) and principles of motivational interviewing can be employed to engage patient while going on to other lifestyle modifications. MOH Lipid Clinical Practice Guideline 2016 categorizes this patient as being at high atherosclerotic cardiovascular risk and statin treatment would be appropriate if LDL cholesterol remains at similar level at review.

CP Practitioner's Signature: _____ **Collaborating doctor's Signature:** _____

Annex A

Prescribing Log Template

CP Practitioners will be expected to complete at least 4 prescribing logs on an annual basis to be included into their CP Competency Portfolio. Patient data must be anonymized to maintain confidentiality.

Signs and Symptoms (including Patient Medical History, medications, clinical examination and findings, allergies)	**Post assessment diagnosis**	**Treatment plan** (drug name, dosage form, dose, frequency, amount)	**Advice, Referral/ Review, Outcome**	**Reflections and Learning points**

CP Practitioner's Signature: _____ **Collaborating doctor's Signature:** _____

Annex B

Continuing Professional Education Log

CP Practitioners must refer to their respective professional boards for maintaining and recording of their Continuing Professional Education ("CPE") points.

NAME:

Date	Record of CPE taken	Number of hours of CPE	Record what you have learnt, how you will apply what you have learnt and what will be beneficial to your area of CP practice?

Glossary of Terms

Medical Practitioner-in-charge

The Medical Practitioner-in-charge ("MPIC") is responsible for the oversight of the clinical management of patients registered with the Advanced Practice Nurse and/or Pharmacists-managed clinics providing Collaborative Prescribing services.

Credentialing Committee

The Credentialing Committee is responsible for the extension of prescribing rights, within an approved scope of practice, to selected Advanced Practice Nurses and/or Pharmacists that have completed the Collaborative Practitioners Prescribing Programme offered by the National University of Singapore.

Collaborative Prescriber Lead

The profession-specific Collaborative Prescriber Lead(s) would be responsible for the welfare of the Collaborative Prescribing practitioner, and the resource person for the Collaborative Prescribing services across the institution.

Service Review Committee

The Service Review Committee is responsible for the regular review and monitoring of the Collaborative Prescribing services across the institution, so as to ensure that the quality and standards of these service are upheld.

Collaborative Prescribing Standing Committee

Chairperson

Prof Alex Sia	Chief Executive Officer, KK Women's and Children's Hospital

Deputy Chairpersons

Ms Paulin Koh	Chief Nursing Officer, Ministry of Health
Dr Camilla Wong	Chief Pharmacist, Ministry of Health

Competency Standards Setting Sub-Committee Chairperson

A/Prof Tham Kum Ying	Education Director and Senior Consultant (Emergency Department), Tan Tock Seng Hospital

Members

A/Prof Sum Chee Fang	Senior Consultant (Endocrinology/Internal Medicine), Khoo Teck Puat Hospital
Dr Lim Pui San	Senior Family Physician, Deputy Head, Toa Payoh Polyclinic
Dr Angel Lee	Medical Director, St Andrew's Community Hospital
Dr Goh Wei Ping	Vice Chairman Medical Board, Alexandra Hospital
Dr Lam Meng Chon	Director (Manpower Standards & Development), Ministry of Health
Dr Ruth Lim	Director (Primary & Community Care), Ministry of Health
Ms Julia Eng	Director (Nursing), National Cancer Centre Singapore
Dr Karen Koh	Deputy Director of Nursing, NUH
Ms Sylvia Lee Ling Ling	Advanced Practice Nurse (Palliative Care), Dover Park Hospice
Ms Wong Yee May	Specialist Pharmacist (Cardiology), Tan Tock Seng Hospital
Mr Saw Yik Chuen	Principal Clinical Pharmacist, Ng Teng Fong General Hospital
Dr Lim Paik Shia	Senior Principal Clinical Pharmacist, Singapore General Hospital

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Collaborative Prescribing Competency Standards Setting Sub-Committee

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Members

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Ms Precilla Lai	Advanced Practice Nurse, Home Nursing Foundation
Ms Joanne Cheng Siow Hue	Senior Nurse Clinician, Advanced Practice Nurse, KK Women's and Children's Hospital
Ms Lim Sheue Fen Stephenie	Principal Pharmacist, Woodlands Health
Ms Oh Wan Lin	Principal Pharmacist, Singhealth Polyclinic
Ms Wee Xue Ting	Chief Executive Officer, iRx Clinical Pharmacy
Dr Zhang Zhi Peng	Head, Choa Chu Kang Polyclinic
Ms Ong Soo Im	Principal Pharmacist (Clinical), National Healthcare Group Pharmacy
Ms Julia Eng	Director (Nursing), National Cancer Centre Singapore
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