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Does the National Competency Standards Framework for Pharmacists in Australia support the provision of behaviour change interventions?

Harjit K Singh¹, Gerard A. Kennedy²,¹,³, Ieva Stupans¹

¹ School of Health and Biomedical Sciences, RMIT University VIC, Australia

² School of Science, Psychology and Sport, Federation University, University Drive, Mount Helen, Ballarat, Melbourne, Australia

³ Institute for Breathing and Sleep, Austin Health, 145 Studley Road, Heidelberg, Melbourne, Australia

Corresponding author
Harjit Kaur Singh
Ph.D. Candidate
Discipline of Pharmacy School of Health and Biomedical Sciences
RMIT University
Bundoora
VIC 3082

Email: s3200840@student.rmit.edu.au
Abstract

Background: Australian pharmacists are increasingly moving towards the provision of patient centred professional pharmacy services. Some of these services are targeted towards improving patients’ health and wellbeing through the facilitation of patient driven health behaviour change. This paper investigates whether the provision of behaviour change interventions by Australian pharmacists is adequately underpinned by the current competency framework.

Method: The foundation and behaviour change competencies within each of the competency domains in the generic health behaviour change competency framework (GHBC-CF), was mapped to Australia pharmacist competency framework.

Results: Although the Australian competency framework underpins most of the foundation and behaviour change competencies of the GHB-CF required to undertake low intensity interventions, for medium to high intensity interventions four specific task related competences need to be addressed. These are: F12 ‘Ability to recognize barriers to and facilitators of implementing interventions’, BC4 ‘ability to agree goals for the intervention’, BC5 ‘capacity to implement behaviour change models in a flexible but coherent manner’ and BC6 ‘capacity to select and skilfully apply most appropriate intervention method’.

Conclusion: Additional training is necessary if pharmacists aspire to provide behaviour change interventions, in particular those that are complex as they involve changes to multiple health behaviours. The identification of these gaps is critical and can potentially be addressed as competency frameworks and pharmacy curricula are updated.

Key words: Competency framework, Behaviour change, Pharmacist, Patient centred, Professional pharmacy services.
Introduction

Australian pharmacists are seeking to redefine themselves and evolve new and extended clinical roles, by increasingly moving towards the provision of patient centred professional pharmacy services. (1) Given that pharmacists are highly accessible health care professionals, and are conveniently available to patients without the need for an appointment, they are in an ideal position to deliver interventions for health education, medication adherence, and prevention and management of chronic health conditions. (2) These interventions are collectively known as professional pharmacy services and require the pharmacist to utilize the knowledge and skills gained through training and education (3, 4) and also incorporate the principles and practices of pharmaceutical care and clinical pharmacy. (5) In delivering professional services pharmacists engage patients to actively contribute to improvements in their health and wellbeing. (6)

The changes to patient health outcomes are a measure of professional pharmacy services and in some cases are dependent on modification of the patient’s behaviour. (7) To successfully implement patient behaviour change, pharmacists must understand the underlying psychological principals (theory) of behaviour change, and have the necessary micro-skills to promote change.

The behaviour change process that patients undergo due to pharmacist-initiated behaviour change interventions is frequently described by the stages of change (SOC) approach. (8-11) The approach was initially used to describe the stages and processes of self-change during smoking cessation. (12) It recognizes that individuals go through five stages of change: (1) pre-contemplation; (2) contemplation; (3) preparation; (4) action; and (5) maintenance. (13) Each stage describes important components in the patients' progress to change and relies on motivation and the readiness to change. (14) Movement from one stage to the next is not possible without fulfilling the previous stage. (14) Therefore, the behaviour change process, as part of this theory, is described as a dynamic cyclic process in which at any one time, an individual is in one of the stages, but may progress to the next or relapse to a previous stage. (15) Progress through the stages can be stimulated by facilitating patient motivation and willingness to change health behaviour/s, hence the definitive need for pharmacists to be competent with the underlying psychological principles and theories of behaviour change. (16)
Since its development, the model has been applied to other forms of behaviour that have negative consequences and can be successfully managed through evolving pharmacist services such as weight loss initiatives (17), chronic disease management (9), alcohol consumption reduction (17) and medication adherence programs (9).

The design and development of undergraduate and postgraduate training curricula, accreditation, the regulation of career entry and career progression for pharmacists is based on competency frameworks. (18, 19) These frameworks are broad, as the definition of competence is heterogeneous and difficult to exclusively define to provide consensus and application to all roles. (20). The national competency standards framework for pharmacists in Australia consists of competency standards which encompass a wide range of skills, knowledge, attitudes, attributes and accompanying behaviour(s) which apply equally to all pharmacists at entry to practice and assure the society that they will practice at benchmark standards at all times. (21-23) Within this framework, the competencies are grouped into domains. There are five domains, each with standards or enabling competencies. Three of these (1.2, 4.1 and 4.2, encompassing professionalism, self-leadership and professional contribution respectively) apply equally to all pharmacists irrespective of the pharmacist’s scope of practice. The remaining enabling competencies apply to pharmacists depending on their area of professional practice (22).

This national competency standards framework for pharmacists in Australia follows a worker-orientated approach as it is focused on the general attributes that pharmacists require to effectively perform their roles. (22, 24) It encompasses a range of personal and professional characteristics, which are assessed, based on performance of pre-defined behaviour/s. It expected that pharmacists maintain and expand upon these characteristics in order to keep up to date with future professional developments. (25) However, this approach has been criticised for its focus on a relatively small number of competencies deemed necessary for practice, often referred to core competencies, as it is possible to overlook other competencies that may also be important. (24, 26) There are no competency standards, which explicitly define the skills and knowledge requirements unique to the future and evolving role of the pharmacist specific to behaviour change interventions within community practice. (22, 27) Pharmacists themselves have also indicated that members may lack professional competence,
confidence, and communication skills necessary for the provisions of these professional services. (28) Therefore, as pharmacists in Australia move towards the provision of behaviour change interventions it is imperative to determine if pharmacists have the specific skills and knowledge required to provide patient centred behaviour change interventions.

The national competency standards framework for pharmacists in Australia include a competency standard, 3.6 that ambiguously refers to promoting health and well-being. Australian pharmacy students receive guidance on providing smoking cessation programs during tertiary education based on this standard. (22, 29, 30) However, this intervention only involves brief opportunistic interactions with patients (31) and uses a generic approach; the 5As, which involves five main steps (ask, advise, assess, assist, arrange). The intervention is initiated by identifying smokers, and then uses interventions appropriate to the patient based upon their willingness to quit. (32, 33) Limited training in behavioural psychology and a lack of practical experience also may make these skills inadequate when applied in professional practice. Furthermore, there is conflicting evidence justifying the effectiveness of existing pharmacist led smoking cessation interventions in Australia. Studies recognize the brief opportunistic interventions as improving cessation rates (33), but also acknowledge the need for additional training and education in order to improve pharmacist’s confidence in implementing evidence-based patient centred smoking cessation services. (32-35)

Hence, there is a need for comprehensive competency frameworks which specifically define the competencies related to the specific roles that pharmacists perform. In this type of framework, competence is considered in a functional sense and is concerned with the successful completion of tasks that constitute a specific task as part of a role. (36) This is apparent within the generic health behaviour change competence framework (GHBC-CF), which describes a comprehensive task related list of competences required by health care workers in order to deliver health behaviour change interventions (37). The document describes in very fine detail competencies, which are arranged into three domains namely; foundation competences, behaviour change competences, and behaviour change techniques in three routes; motivation development, action on motivation and prompted cues. Furthermore, within each of the domains the competencies are organized into three levels, which are
characterized by the intensity of the health behaviour change intervention to be delivered: (1) low intensity interventions, are interventions delivered following a protocol with restricted flexibility for changes by the provider; (2) medium intensity interventions are those for which there is an established protocol, although it allows for some flexibility in the delivery by the practitioner; and (3) high intensity interventions are flexible interventions that are adapted to suit the patient’s needs. The hierarchy of intervention intensity is cumulative and competency to work at any given level assumes performance of enabling competencies described at the lower levels. (37)

In accordance with the GHBC-CF, weight loss initiatives, chronic disease management, medication adherence programs and health coaching are medium intensity behaviour change interventions. Considering that Australian pharmacists provide these services with limited training in behavioral psychology (31) it is important to identify specific gaps in competences required to provide behaviour change interventions.

The aim of this paper was to identify specific elements? Skills? ?Skill-sets?, which need to be addressed to enable Australian pharmacists to effectively deliver patient centred behaviour change interventions.

**Method**

A qualitative descriptive methodology was employed in this study. The foundation and behaviour change competencies within each of the domains in the GHBC-CF. (37) were mapped to the Australia pharmacist competency framework. (22) The competency domains within the GHBC-CF are shown in Table 1. A comparative document analysis [27] was subsequently performed. Mapping of the competencies was undertaken by one author and checked by two other authors. Table 2 was populated with the Australian pharmacist competencies against the competencies of the GHBC-CF. A detailed version of the mapping process is given in the Appendix.

**Results**

Mapping of the foundation competences of the GHBC-CF (37) with the competency framework for Australian pharmacists (22) indicated that the Australian competency framework underpins all of the foundation competencies required to undertake low intensity behaviour change interventions (Table
However, the Australian competency framework did not underpin all the specific behaviour change competences required for low intensity interventions; it did not support BC4 ‘ability to agree goals for the intervention’ (Table 2). Furthermore, the foundation competence F12 ‘capacity to deal with barriers to and facilitators of implementing interventions’ required to perform both medium and high intensity interventions did not map to the Australian competency framework (Table 2). The behaviour change competences BC5 ‘capacity to implement behaviour change models in a flexible but coherent manner’ and BC6 ‘capacity to select and skilfully apply most appropriate intervention method’, required to perform high intensity interventions also did not map to the Australian competency framework (Table 2).

Discussion

Australian community pharmacists are in an ideal position to capture populations not motivated to use mainstream health services. (31) They can do this through the delivery of a number of health promotion services which focus on behaviour change and include smoking cessation (17), weight management (17), alcohol reduction support (17) and chronic disease management programs such as health coaching. (16, 31) Implicitly, these services can improve public health; however, a potential barrier to their delivery is the level of skill and confidence of the pharmacist. (31, 38) Mapping of the GHBC-CF competences (37) to the Australian pharmacist competency framework (22) indicated all the foundation competencies required to provide low level behaviour change interventions were met by the Australian competency framework. However, pharmacists require additional training for the behaviour change competences for low-level interventions (Table 2), specifically, pertaining to the behaviour change competence BC4 ‘ability to agree goals for the intervention’. This competence requires intervention providers to work collaboratively with patients. As pharmacists are traditionally accustomed to using a generic style of counselling, involving a linear, one-way process lacking patient-centred discussions, additional training is justified. (39) By contrast, although domains 1, 2 and 3 of the Australian pharmacist competency framework refer to the provision of patient centred care, they are overarching in order to comply with the delivery of a range of services, and thus do not underpin the granular competences of the GHBF-CF referring to the delivery of patient centred care.
behaviour change interventions. Pharmacists have the underlying skills for the delivery patient centred services, training specifically for behaviour change interventions should focus on the intervention itself; the theoretical framework and the process involved.

The competences for low intensity interventions, which are delivered following a protocol with a restricted flexibility to accommodate for changes, must be achieved to provide interventions at higher intensity levels. Evident from the results (Table 2) Australian pharmacists require additional training to enable the provision of medium-high-level intensity behaviour change interventions, which offer flexibility in delivery. The Australian pharmacist competency framework does not encompass the foundation competency F12 ‘capacity to deal with barriers to and facilitators of implementing interventions’ of the GHBC-CF (Table 2). This foundation competence is dependent on having the skills and knowledge required to implement behaviour change interventions and subsequently being able to recognize barriers and facilitators to the behaviour change intervention, specific to themselves, the patient, and the physical surroundings. (37) Although, the Australian competency framework refers to the pharmacist’s ability to identify facilitators of patient centred care in domains 1, 2 and 3 and the ability to identify problems towards patient care in domain 2, it does not allude to behaviour change.

In addition to smoking cessation, most pharmacy curricula also include weight-management education. (40) Despite this, a survey of pharmacy students from one Australian university indicated that students felt that their knowledge and confidence was insufficient to provide weight-management services in their future career. (40) Likewise to this, interviews with pharmacists (n = 537) about their involvement in weight loss interventions showed that 91.6% requested further training. (40)

Therefore, given that the educational interventions delivered by pharmacists have a limited ability to produce behavioural change, (31) supporting the evolving role of pharmacists is imperative towards health promotion in Australia. Reference to behaviour change in the pharmacist competency framework and in tertiary curricula may ensure that pharmacists are skilled to provide these services safely, and confidently.
Mapping of the GHBC-CF to the Australian competency framework showed that pharmacists also require additional training to attain the behaviour change competences, BC5 ‘capacity to implement behaviour change models in a flexible but coherent manner’ and BC6 ‘capacity to select and apply most appropriate intervention method’ required for high intensity interventions (Table 2). These competences describe the specific knowledge about and the skills for the delivery of behaviour change interventions. Since the Australian competency framework for pharmacists is broad, allowing for expansive and flexible scope of practice (22), it does not encompass distinct competencies for the various roles that pharmacists employ, such as providers for behaviour change interventions.

Comparably, this is also emphasized by the outcomes of a study, which mapped the competencies of pharmacists from Australia, Canada, New Zealand, the United Kingdom, and the United States to the competencies required to health coach. The results showed that overall the Australian competency framework supported Australian pharmacists to coach, however the one enabling competency which was missing was around confidence (38). Without furthering their knowledge and developing skills in health psychology and the underlying theories of behaviour change, it is unlikely that pharmacists will achieve a level of confidence that will allow them to deliver behaviour change interventions required for health coaching (16), weight loss initiatives (17), chronic disease management (9), alcohol reduction (13, 17) and medication adherence programs (9).

Considering that behaviour change interventions are often complex and is associated with patients having moderate or complex physical co-morbidities and with moderate mental health co-morbidities (37), it is plausible that these conditions could not be managed by the community pharmacist but rather one with advanced practice knowledge and qualifications. (41) Though, it is important to note that likewise to the competency framework for Australian pharmacists (22), the framework for advanced practice pharmacists in Australia does not underpin the competencies required for behaviour change interventions (41). In addition, both frameworks did not refer to the techniques facilitating behaviour change. (22, 37, 41) Contemporarily, it is recognised that several factors; social, environmental, individual, physiological, biological, and cultural components influence public health problems including obesity and chronic health conditions. Facilitating positive changes to these
complex health conditions (42) involve adapting the intervention to patients and the multiple health
behaviours and factors influencing it. (43) Hence, the need for pharmacists to build on their existing
competences and attain the skills and knowledge required to facilitate positive changes to the health
behaviours of their clients.

England has responded to the advancing role of pharmacists in public health by introducing the
consultation skills standards for pharmacy practice package, which addresses the need for patient
centred care, by facilitating behaviour change through effective communication and collaborative
inter-professional discussions. (16, 44) Implementation of the tool has shown that while it provides a
foundation for adopting a patient-centred approach in the pharmacy (45), continued practical support
and experience is required to establish the standards into daily work practices. (46) Similar tools have
also been implemented by the USA and Canada; the Patient-centred Communication Tools (PaCT)
and the Calgary-Cambridge guide (C-Cg) respectively. (47) Although, these tools also provide
instructional guidance they offer limited scope to address the holistic approach required for the
delivery of patient centred services. (47)

Although pharmacists in Australia have most of the foundation and behaviour change competencies
within the GHBC-CF (Table 2), several gaps have been identified. As these pharmacists broaden their
professional roles towards the provision of patient centred health promotion services (31), it is
imperative that the skills, knowledge, attitudes and behaviours needed for these consultations be
clearly defined, comparable to those introduced by international counterparts. (44, 47) The studies
examining the international consultation tools provide Australian pharmacy educators and curriculum
developers the scope to build on the existing tools and to ensure that the gaps identified within the
GHBC-CF (Table 2) are met. This would ensure that graduates receive thorough training and are
qualified to adopt these integrative patient centred roles at entry to practice.

Limitations

A limitation is this work is that it is qualitative; therefore, this study has the potential to be influenced
by researcher biases. However, to minimize this, the research team utilized the method of content
analysis, and cross checking of results. Furthermore, the results of this study do not outline a specific
training process for pharmacists in Australian to provide behaviour change interventions. It does, however, identify gaps within the Australian pharmacy competency framework, which would need to be promptly addressed within pharmacy curriculums, practice guidelines and training, given that pharmacists are currently providing these services.

Conclusion

The Australia pharmacist competency framework does not underpin all the competencies identified as being required for low, medium, and high intensity interventions within the GHBC-CF. The few competencies for which pharmacists require additional training are F12 ‘Ability to recognize barriers to and facilitators of implementing interventions’, BC4 ‘ability to agree goals for the intervention’, BC5 ‘capacity to implement behaviour change models in a flexible but coherent manner’ and BC6 ‘capacity to select and skilfully apply most appropriate intervention method’. Some of these competences are imperative to the provision of basic low-level interventions and provide the groundwork for the delivery of more complex interventions such as health coaching, weight loss initiatives, chronic disease management, alcohol reduction and medication adherence programs. Therefore, addressing these competency gaps through the introduction of comprehensive guidelines and task specific training is imperative, as it would enable pharmacists with the confidence and skills to provide these interventions at entry to practice.
List of abbreviations


Authors’ contributions

The results were mapped by HS and were subsequently verified by IS. GK reviewed the results when consensus could not be reached. All authors participated in drafting the manuscript. All authors read and approved the final manuscript.

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Availability of data and materials

No data is available since this study did not involve any human participant.

Ethics approval and consent to participate

No ethics committee approval was needed since this study did not involve any human participant.

Consent for publication

Not applicable.

Competing interests

The authors have nothing to disclose.
Table 1. A detailed summary of the competencies within each domain and at the intervention levels (adapted from Dixon and Johnston (37)).

<table>
<thead>
<tr>
<th>Foundation Competences</th>
<th>Behaviour Change Competences</th>
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<tbody>
<tr>
<td><strong>Low Intensity Interventions</strong></td>
<td></td>
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<tr>
<td>F1</td>
<td>F2</td>
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<td></td>
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<tr>
<td><strong>Medium Intensity Interventions</strong></td>
<td></td>
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<tr>
<td>F1</td>
<td>F2</td>
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<tr>
<td><strong>High Intensity Intervention</strong></td>
<td></td>
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<tr>
<td>F1</td>
<td>F2</td>
</tr>
</tbody>
</table>
Table 2. Australian pharmacist competency framework domains mapped to generic health behaviour change competency framework (GHBC-CF)

<table>
<thead>
<tr>
<th>Domain 1: Professionalism and ethics</th>
<th>Foundation Competences</th>
<th>Behaviour Change Competences</th>
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<tbody>
<tr>
<td></td>
<td>F1 F2 F5</td>
<td>BC8 BC9</td>
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<td></td>
<td>F7 F8 F9</td>
<td></td>
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<tr>
<td>Domain 2: Communication and collaboration</td>
<td>F1 F3 F4 F5 F6</td>
<td>BC7 BC8</td>
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<td></td>
<td>F7 F8 F9 F10</td>
<td></td>
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<tr>
<td>Domain 3: Medicines management and patient care</td>
<td>F1 F7 F8 F10 F11</td>
<td>BC1 BC12</td>
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<td></td>
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<tr>
<td>Domain 4: Leadership and management</td>
<td>F1 F7</td>
<td>BC1 BC2 BC3</td>
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<td></td>
<td></td>
<td>BC8 BC10 BC11 BC12</td>
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<tr>
<td>Domain 5: Education and research</td>
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<tr>
<td></td>
<td>F8</td>
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</table>
References


15. Levinson W, Cohen MS, Brady D, Duffy FD. To change or not to change:“Sounds like you have a dilemma” . Annals of internal medicine. 2001;135(5):386-91.


20. Lingard L. What we see and don’t see when we look at ‘competence’: notes on a god term. Springer; 2009.


## Appendix

**Detailed table outlining mapping process of Australian pharmacist competencies to the foundation and behaviour change competencies of the GHBC-CF**

<table>
<thead>
<tr>
<th>Australian pharmacist competency Domains</th>
<th>Competency Standards</th>
<th>Foundation Competencies</th>
<th>Behavior Change Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 1: Professionalism and ethics</strong></td>
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<td></td>
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<tr>
<td>1.1 Uphold professionalism in practice</td>
<td></td>
<td>F1, F5</td>
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<tr>
<td>1.2 Observe and promote ethical standards</td>
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<td>F1</td>
<td></td>
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<td>1.3 Practice within applicable legal framework</td>
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<tr>
<td>1.4 Maintain and extend professional competence</td>
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<td>F1</td>
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<tr>
<td>1.5 Apply expertise in professional practice</td>
<td></td>
<td>F1, F7, F8, F9</td>
<td></td>
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<tr>
<td>1.6 Contribute to continuous improvement in quality and safety</td>
<td></td>
<td>F1, F2, BC8, BC9</td>
<td></td>
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<tr>
<td><strong>Domain 2: Communication and collaboration</strong></td>
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<tr>
<td>2.1 Collaborate and work in partnership for the delivery of patient centred, culturally responsive care</td>
<td></td>
<td>F1, F3, F5, F7, F10</td>
<td>BC8</td>
</tr>
<tr>
<td>2.2 Collaborate with Professional colleagues</td>
<td></td>
<td>F1</td>
<td>BC7</td>
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<tr>
<td>2.3 Communicate effectively</td>
<td></td>
<td>F4, F6, F9</td>
<td></td>
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<tr>
<td>2.4 Apply interpersonal communication skills to address problems</td>
<td></td>
<td>F1, F8, F9, F10</td>
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<tr>
<td><strong>Domain 3: Medicines management and patient care</strong></td>
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<tr>
<td>3.1 Develop a patient centred, culturally responsive approach to medication management</td>
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<td>F11</td>
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<td>3.2 Implement the medication management strategy or plan</td>
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<td>3.3 Monitor and evaluate medication management</td>
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<td>3.4 Compound medicines</td>
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<td>3.5 Support Quality Use of Medicines</td>
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<tr>
<td>3.6 Promote health and well-being</td>
<td></td>
<td>F1, F7, F8, F10</td>
<td>BC1, BC12</td>
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<tr>
<td>Domain 4: Leadership and management</td>
<td>4.1 Show leadership of self</td>
<td>F7</td>
<td>BC2</td>
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<tr>
<td>4.2 Manage professional contribution</td>
<td>F1, F7</td>
<td>BC3, BC4, BC8, BC10, BC11, BC12</td>
<td></td>
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<tr>
<td>4.3 Show leadership in practice</td>
<td>F1</td>
<td></td>
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<tr>
<td>4.4 Participate in organizational planning and review</td>
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<td>4.5 Plan and manage physical and financial resources</td>
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<tr>
<td>4.6 Plan, manage and build human resource capability</td>
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<tr>
<td>4.7 Participate in Organizational management</td>
<td>F1</td>
<td>BC1</td>
<td></td>
</tr>
<tr>
<td>Domain 5: Education and research</td>
<td>5.1 Deliver education and training</td>
<td>F8</td>
<td></td>
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<tr>
<td>5.2 Participate in research</td>
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<tr>
<td>5.3 Research, synthesize and integrate evidence into practice</td>
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