Consultation: Two proposals for registered nurse prescribing

Submission Form

Please read and refer to the consultation document Two proposals for registered nurse prescribing available on the Nursing Council of New Zealand website www.nursingcouncil.org.nz before completing this form. The questions in this form are designed to help you to focus your response and make it easier for us to analyse submissions. However, you don’t have to answer every question and may add additional comments.

This submission was completed by:

Name:

Address: Pharmaceutical Society of New Zealand

Email:

Organisation: Pharmaceutical Society of New Zealand

Position:

If an email address is supplied, we will notify you of when the report of the summary of submissions is published on-line.

You are making this submission:

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Please indicate which part of the sector your submission represents:

☐ Individual nurse ☐ Individual doctor
☐ Individual other ☐ District Health Board
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In the interests of a full and transparent consultation process, the Nursing Council intends to publish a report which may contain quotes from the submissions received. The Council may also publish the submissions received on this consultation document on its website. However, if you object to this publication or to the publication of your name (Please note that the names of individual submitters will not be published) tick one or both of the following boxes:

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**The deadline for feedback is Friday 19 April 2013.** Submissions are accepted in written and email form. Please save and send your submission to:

EmmaG@nursingcouncil.org.nz

Or post to:

Emma Gennard  
Nursing Council of New Zealand  
PO Box 9644, Wellington 6141
Consultation questions

The consultation questions are split into two parts specific to the two proposals. Respondents are asked to reply to questions about both proposals. There is an opportunity at the end of the questions to give general views on the consultation paper and models of nurse prescribing.

Proposal One: Community nurse prescribing

Proposal for community nurse prescribing

The Council believes that registered nurses working in schools, general practice, public health, Maori and Pacific Health providers, services for youth, family planning and other ambulatory services already have a significant role in health promotion, disease prevention and in the assessment and treatment of minor ailments and illnesses. The ability to prescribe a limited number of medicines would enhance the health services registered nurses are able to deliver to some patients in community and outpatient settings.

1.1 Do you agree with the proposal that suitably qualified and experienced registered nurses be able to prescribe a limited list of medicines to treat minor ailments and infections, and to promote health?

Yes ☒ No ☐

The rationale for extending nurse prescribing is to improve patient care without compromising patient safety; make it easier for patients to obtain the medicines they need; increase patient choice in accessing medicines; and make better use of the skills of health professionals.

1.2 Do you agree that community nurse prescribing will enable patients to receive more accessible, timely and convenient care?

Yes ☐ No ☒

From the descriptions outlined in the consultation document, The Pharmaceutical Society does not believe a specific community nurse prescriber scope would provide the benefits described. We also found that the proposed list of medicines does not seem to correlate with the more narrow breadth of practice described for this prescriber type.

The Pharmaceutical Society fully acknowledges that “registered nurses already have a significant role in health promotion, disease prevention and in the assessment and treatment of minor ailments and illnesses”. We also understand the frustration expressed in an “inability to prescribe medicines which are available for patients to purchase at retail outlets and pharmacies (over the counter medicines)”. However an ability to prescribe such medicines will not necessarily improve accessibility or patient care, as whether a community nurse prescriber (CNP) visits the patient in

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1 Health services provided on an outpatient basis to those who visit a hospital or another health care facility and depart after treatment on the same day.
their home, or a rural or other located clinic, any prescription generated will still need to be
presented to a pharmacy for dispensing; and many of these medicines are not subsidised. We agree
that there does need to be a better mechanism for accessed to subsidised medicines for minor
ailments able to be treated over the counter, but this is not necessarily an argument for the
development of a specific prescribing scope when existing prescribers and pharmacists themselves
are not able to access funding for these.

Currently, prescriptions presented for unsubsidised medicines that are available for purchase over
the counter are not usually dispensed by pharmacists – otherwise in addition to the cost of the
medicine, the patient would be required to pay a dispensing fee. Instead, most pharmacists will just
sell the medicine over the counter by retail.

With respect to vaccines, approved vaccinators meeting Ministry of Health immunisation standards
are permitted to administer vaccines under direction of Medical Officers of Health or medical
prescribers. Furthermore, these are not actually prescribed as such, as they are directly administered
to the patient. A patient does not receive a prescription for vaccines to be dispensed by a pharmacist
(unless it was an oral vaccine perhaps, but this would be relatively rare).

Title for community nurse prescribing
The Council has used the title “community nurse prescribing” for this proposal but is aware that it
may not best describe the nurses who may undertake this type of prescribing or the breadth of the
prescribing authority.

1.3 Do you consider the title “community nurse prescribing” adequately describes and informs
the public and other health professionals of the breadth of this prescribing authority?
Yes [ ] No [x]

The Society does not consider that this title adequately describes the role or breadth of prescribing
authority; particularly considering the list of medicines proposed to be available to this prescriber
type. We believe the area of practice and breadth of conditions to be managed should be clearly
defined then an appropriate list of medicines to meet this need can be developed.

Scope of practice and authorisation for community nurse prescribing
The Council is proposing to add the following sentence to the scope of practice for registered nurses
to allow some registered nurses to be authorised for community nurse prescribing:

“Some nurses with additional experience education and training may be authorised by the
Council to prescribe some medicines within their competence and area of practice.”

1.4 Do you agree with the suggested wording changes to the registered nurse scope of practice
and with a prescribing authorisation being included in the scope of practice of registered
nurses with community nursing prescribing authority?
Yes [ ] No [x]
Wording of current legislation and regulations related to prescribing has moved towards “prescribing within the practitioner’s scope of practice” type of concepts. This limited definition added to the “general” registered nurse scope of practice is not sufficient for dispensing pharmacists to determine the legitimacy of a prescription. Having a list of nurses able to prescribe within the proposed CNP definition along with a list of medicines permitted to be prescribed does provide useful information for dispensing pharmacists to check, but the loose wording as an add-on to the general nursing scope we believe does not provide a sufficient means for prescribing accountability.

Qualification and training for community nurse prescribing

It is proposed that community nurse prescribing courses should include up to 6 days of theory (online and workshop) and 3 days of prescribing practice with a doctor or nurse prescriber (authorised prescriber). A competence assessment with a doctor or nurse practitioner would be one of the course assessments that must be successfully completed before the nurse would be authorised by the Council to prescribe. The standards for community nurse prescriber courses are outlined on page 50 of the consultation document. The competencies that the registered nurse will be assessed against are on page 53.

1.5 Do you agree that the proposed education and training for community nurse prescribing is consistent with their scope of practice and their prescribing authority and will enable them to demonstrate competent and safe prescribing practice?

Yes ☐ No ☒

1.6 Do you agree with the course standards for community nurse prescribers?

Yes ☐ No ☒

1.7 Do you agree with the competencies for community nurse prescribers?

Yes ☐ No ☒

We disagree with the proposed education and training for community nurse prescribing and believe this will not enable them to demonstrate competent and safe prescribing practice.

The proposed “up to 6 theory days with a mixture of on-line learning and workshop attendance and three days supervised practice with an authorised prescriber mentor” considerably underestimates the knowledge and skills required to prescribe medicines safely and competently. Even recognising a specified level of entry criteria to gain entry to a training programme, the degree of knowledge required to be taught on pharmacology, pharmacokinetics, therapeutics and adverse reactions/interactions etc requires a great deal more training than what is provided for. Then further consideration is required with training on the legal, ethical and further regulatory requirements of prescribing which are complicated and multifactorial.

The course standards proposed for CNP do largely describe the training requirements required, which is why we disagree with the proposed mechanism and time allowed for effective delivery of such training.

We are not able to state our agreement with the proposed assessment as it is not sufficiently detailed.
Entry criteria for courses leading to community nurse prescribing

The Council is proposing the following criteria to gain entry to a community nurse prescribing programme:

- The registered nurse must hold a current annual practising certificate and must have completed three years equivalent full time practice. At least one year must be in the area of practice she/he will be prescribing.
- The nurse must have support from his/her employer to undertake the prescribing course and must confirm that they will be able to prescribe in their work role at the completion of the course.
- The nurse must have the support of an identified authorised prescriber mentor who will support her/him to prescribe.
- The nurse must be employed by an organisation that supports nurse prescribing through policy, audit, peer review and accessibility of continuing education.

1.8 Do you agree with the entry criteria for community nurse prescribing courses?

Yes ☐ No ☒

The final point listed in the entry criteria with respect to nurses having to be “employed by an organisation that supports nurse prescribing through policy, audit, peer review and accessibility of continuing education” may be difficult to meet for some nurses working alone in relative isolation perhaps without such strong peer support networks, such as some school nurses.

Continuing competence and monitoring for community nurse prescribing

It is proposed that nurses who have community nurse prescribing rights be required to participate in peer review of their prescribing practice and complete professional development on prescribing each year (e.g. a community nurse prescriber’s update). Community nurse prescribers must also be able to demonstrate that they have completed 60 days of prescribing practice within the past three years. The Council is proposing that it monitors that these requirements are met every 3 years at practising certificate renewal.

1.9 Do you agree with the ongoing continuing competence requirements for community nurse prescribers?

Yes ☒ No ☐

Not entirely. It should be a mandatory requirement for prescribers to complete a defined number of hours of continuing education / continuing professional development within their clinical area of prescribing practice to ensure currency of knowledge and skills.
Indicative list of medicines for community nurse prescribing

The medicines lists for community nurses were developed from the New Zealand Formulary and Pharmaceutical Schedule for medicines to treat identified therapeutic areas. The lists contain commonly used medicines for minor ailments, prevention of disease, common skin conditions and infections and contraceptives. Please refer to the lists on page 21 of the consultation document.

1.10 Do you agree with the proposed list of prescription medicines that nurses with community prescribing rights will be able to prescribe as designated prescribers?

Yes □ No □

The proposed list of medicines highlights to The Society an inconsistency with the proposed scope and function of this prescriber type. While the function describes a “lower qualification level” for a nurse prescribing for minor ailments relatively independently, many of the medicines listed do not fit this. Many of the medicines listed are for specialist use, for diagnostic purposes or for the emergency or acute management of more serious conditions. Others are not specifically used therapeutically on their own (either for clinical or pharmaceutical reasons), or a product is not generally available to supply.

A medicines list should be based upon a clearly defined scope, area of practice and the conditions proposed to be managed, and not in response to access funding criteria (which is constantly changing). The problem this presents for the proposed CNP is that many of the medicines used for the management of these “minor ailments” / “primary care-managed conditions” are already available over the counter, and because many of these are not funded, there would be no benefit in making them available via a prescription. If the funding status was changed to accommodate these, there would be a significant increase in the government’s pharmaceuticals budget - as we would expect access to funding for such medicines would not be limited to the CNP.

Many medicines listed are pharmaceutical ingredients which are not usually prescribed on their own. We would not expect the training for the CNP to cover pharmaceutical formulations used in clinical practice, therefore rather than specifying an extensive list of ingredients and expecting prescribers specify their own formulae, perhaps a defined list of formulations could be specified for prescribing? Similarly, we do not see a need to specify the proposed “Community Nurse Non Medicine list” which the consultation document explains is so that “their exclusion did not prohibit nurse prescribers from being able to access the medicines in which they are contained”. Any prescriptions for products containing these ingredients would be prescribed by product name or by the predominant therapeutic ingredient. This list is not required in our opinion.

The Emergency Contraceptive Pill is already available for nurses “recognised by their professional body as having competency in the field of sexual and reproductive health”, as defined in the medicine classification for levonorgestrel.

Comments on specific agents listed include:
3. adrenaline sympathomimetic IV for emergency use only
4. alcohol disinfectant/antiseptic Topical only (not IV). Not generally dispensed to patients on prescription.
6. amethocaine ocular anaesthetic Do not see a prescribing need for an ocular anaesthetic
11. atropine antimuscarinic Specialist or emergency use and/or for acute ocular use (not chronic therapy)
15. benzathine penicillin antibacterial Only available IM for specific serious infections
16. benzocaine local anaesthetic Only available combined with tetracaine and indicated for topical anaesthetic for dental procedures
23. camphorated oil aromatic Unlikely clinical need
25. ceftriaxone antibacterial Restricted use clinically
27. chloramphenicol antibacterial Only topical not oral or IV
28. chloroform anaesthetic Not best practice clinically
32. cimetidine H2 antagonist Not first line, significant drug interactions and worse side effect profile compared to similar agents.
34. ciprofloxacin antibacterial Not first line antibiotic – specialist use only
42. cyclosporin antipsoriatic Narrow therapeutic index drug requiring clinical monitoring beyond the scope of a community nurse, even if restrict for use in psoriasis only. Risk for toxicity
43. cyproterone hormonal contraceptive Only when combined with ethinyloestradiol.
44. danthron laxative Use restricted for palliative care only
71. fluorescein ophthalmic diagnostic Used for diagnostic purposes only
92. ketoconazole antifungal Specialist use. Significant interactions
101. triethanolamine lauryl sulphate antipsoriatic Not available as a prescribable product?
Non prescription medicines will not be included in the regulation but patients may be able to access a subsidy if the item is “prescribed” by a nurse with community nurse prescribing authority.

1.11 Do you agree that community nurse prescribers should be able to access this list of non prescription medicines?
- Yes ☒
- No ☐

A prescription for a medicine is used either because the medicine is classified as a prescription medicine (and hence is a legal requirement for supply/possession) OR it is a means of obtaining funding or subsidised treatment. Many medicines not classified as a prescription medicine are available to be subsidised if written on a prescription, however many are not.

The problem this presents for the proposed CNP is that many of the medicines used for the management of these “minor ailments” / “primary care-managed conditions” are already available over the counter, and because many of these are not funded, there would be no benefit in making them available via a prescription. If the funding status was however changed to accommodate these, there would be a significant increase in the government’s pharmaceuticals budget.

Proposal Two: Specialist nurse prescribing

Proposal for specialist nurse prescribing
The Council is proposing that registered nurses with advanced skills and knowledge who work in specialty services (e.g. diabetes services) or expert nurses working in general practice teams in the community be authorised to prescribe medicines for patients who have common conditions e.g. asthma, diabetes, hypertension. They would work as part of a collaborative multidisciplinary team and manage and monitoring patients with these conditions in clinics or by providing home based care. They will seek assistance from a doctor within the team when making difficult or complex clinical decisions.

2.1 Do you agree with the proposal that suitably qualified and experienced registered nurses be able to prescribe from the specialist and community nurse prescribing lists of medicines?
- Yes ☒
- No ☐

The ability of specialist nurses to prescribe will mean that they can make a greater contribution to patient care particularly in chronic or long term condition management. Prescribing authority will ensure competence and accountability for the medication decisions specialist nurses make and be convenient for patients who will no longer have to see a doctor for routine monitoring and prescriptions.

2.2 Do you agree that specialist nurse prescribing will enable patients to receive more accessible, timely and convenient care?
Title for specialist nurse prescribing

The Council has used the title “specialist nurse prescribing” for this proposal but is aware that it may not best describe the nurses who may undertake this type of prescribing (some of whom may be generalist practice or rural nurses) and could be confused with nurses who do not prescribe or have different roles eg clinical nurse specialists.

2.3 Do you consider the title “specialist nurse prescribing” adequately describes and informs the public and other health professionals of the breadth of this prescribing authority?

Yes ☒ No ☐

The Council is proposing that nurses with specialist nurse prescribing authority work in a collaborative relationship within a multidisciplinary team. Specialist nurse prescribers will refer a patient who has a health concern or complexity which is beyond their level of competence to a doctor. The Council believes that ongoing supervision by a medical mentor is unnecessary as specialist nurses must work within a team and within their level of competence.

2.4 Do you agree that nurses with specialist nurse prescribing authority should be required to work in a collaborative multidisciplinary team?

Yes ☒ No ☐

2.5 Do you think that nurses with specialist nurse prescribing authority should also be required to practice under supervision for six months when they begin to prescribe?

Yes ☒ No ☐

The proposed title implies specialisation in a clinical area of practice as opposed to a nurse with advanced knowledge in general areas of practice. Particularly as the prescribing breadth described specifies the ability to “diagnose and treat common conditions (eg. asthma, diabetes, hypertension)”. The Society understands the concept of this type of nurse prescriber as distinct from the functions of the “nurse practitioner” (which is expected to become an authorised prescriber and practices in a specialised clinical area of practice). However we believe the “common” and “chronic conditions” available to this prescriber requires clearer definition to ensure prescribing within scope. Following this clearer definition, an appropriate list of medicines should be able to be developed.

Scope of practice for specialist nurse prescribing

The Council is consulting on two options for specialist nurse prescribing. The first is to introduce a new scope of practice – specialist nurse prescriber. The second option is for specialist nurse
prescribing to be included as an authorisation\(^2\) in a registered nurse’s scope of practice. The first option would more clearly inform the public and other health professionals of the qualification and skills of a nurse with this prescribing authority. The second option may reduce expectations of increased remuneration and would be more acceptable to nursing organisations.

2.6 Do you agree that nurses who apply for specialist nurse prescribing authority should be:

- [x] a) registered in a new scope of practice; or
- [ ] b) have a condition/authorisation included in the registered nurse scope of practice

2.7 If nurses with specialist nurse prescribing authority are registered in a specialist nurse prescriber scope of practice, do you agree with the scope statement on page 34 of the consultation document?

Yes [x] No [ ]

2.8 If nurses with prescribing authority have a condition/authorisation, do you agree with the proposed additional wording in the registered nurse scope of practice?

“Some nurses with additional experience education and training may be authorised by the Council to prescribe some medicines within their competence and area of practice.”

Yes [ ] No [x] / N/A

The overall intended role of the ‘specialist nurse prescribing’ scope described is reasonable, however

The Society would recommend the use of an alternative name such as “advanced nurse prescriber” or “general nurse prescriber” or similar. Such titles better reflect how prescribing is not limited to a medical specialty and would not be confused with current wording and definitions of “specialists” in the Pharmaceutical Schedule and medicines legislation and regulations.

The Society believes the responsibility and accountability for prescribing activities require a scope of practice separate to “general” or more “traditional” practice activities. Despite concerns expressed in the consultation document, we do not believe expectations related to remuneration should influence whether or not a specific scope of practice be created.

**Qualification and training for specialist nurse prescribing**

The Council is proposing that specialist nurse prescribers complete a post graduate diploma in specialist nurse prescribing. The programme would be pathophysiology of common conditions, assessment and clinical decision making (diagnosis), pharmacology and prescribing praxis which would include 150 hours of supervised practice with a designated medical prescriber. The standards for specialist nurse prescriber courses are outlined on page 54 of the consultation document. The

\(^2\) Under section 22 of the Health Practitioners Competence Assurance Act 2003, the Council may change a scope of practice and state the health services a nurse is able to perform.
Council is proposing that nurses applying for specialist nurse prescribing rights must have satisfactorily completed this qualification including an assessment of their competence to prescribe (see competencies on page 64) by the medical mentor before being authorised to prescribe.

2.9 Do you agree that the proposed education and training for specialist nurse prescribing is consistent with their scope of practice and their prescribing authority and will enable them to demonstrate competent and safe prescribing practice?

Yes ☐
No ☒

2.10 Do you agree with the standards for accreditation of courses for specialist nurse prescribing?

Yes ☒
No ☐

2.11 Do you agree with the proposed competencies for specialist nurse prescribers?

Yes ☒
No ☐

As for the Community Nurse Prescriber, the course standards proposed for “specialist nurse prescribing” do largely describe the training requirements required, which is why we disagree with the proposed mechanism and time allowed for effective delivery of such training. We are not able to state our agreement with the proposed assessment as it is not sufficiently detailed.

The report by Hacking and Taylor referenced in the consultation document notes that pharmacology training was considered insufficient by some in the UK prescribing training programmes, and this is perhaps confirmed by survey respondents in the study indicating pharmacology as a continuing professional development need post qualification as a prescriber.

As a comparison, the pharmacist prescribing post graduate qualification will be equivalent to 600hrs of study and include a prescribing practicum. The prescribing practicum must consist of 300hrs and include at least 20 x 7.5 hr days (i.e. 150 hours out of the 300hours) of supervised practice under a Designated Medical Practitioner (DMP). The pre-requisite qualification for entry into this prescribing qualification is a post graduate Diploma in Clinical Pharmacy or equivalent. The prerequisite qualification must include at least 600 hours of applied pharmacotherapy. This is on top of a 4 year undergraduate degree plus one preregistration training year with a predominant focus on the actions and use of medicines and their therapeutic use.

The Society believes that training and experience in practicing with a greater emphasis in pharmacotherapy, pharmacology and pharmacokinetics is not generally a particular focus for nursing practice and hence a greater emphasis in the Pharmacology Learning Outcomes in particular are required in the prescribing training.

Entry criteria

The Council is proposing that the registered nurse must meet the following criteria before gaining entry to a prescribing programme:

- The registered nurse must hold a current annual practising certificate and must have completed three years equivalent full time practice. At least one year must be in the area of practice she/he will be prescribing.
• The registered nurse must have support from her employer to undertake the Postgraduate diploma in specialist nurse prescribing and must confirm that they will be able to prescribe in their work role at the completion of the course.

• The registered nurse must have the support of an identified prescriber mentor who will support her/him to prescribe.

• The registered nurse must be employed by an organisation that supports nurse prescribing through policy, audit, peer review and accessibility of continuing education.

2.12 Do you agree with the entry criteria for specialist nurse prescribing programme?

Yes ☒ No ☐

Continuing competence and monitoring

The Council proposes that nurses who have specialist nurse prescribing rights be required to undertake regular case review of their prescribing practice with a suitable mentor and complete professional development hours each year on prescribing within the 60 hours of professional development completed by all nurses every three years. Specialist nurse prescribers must also be able to demonstrate that they have completed 60 days of prescribing practice within the past three years. The Council is proposing that it monitors that these requirements are met every 3 years.

2.13 Do you agree with the continuing competence requirements for specialist nurse prescribers?

Yes ☒ No ☒

Not entirely. As answered for the “community nurse prescriber”, we believe there should be a mandatory requirement for prescribers to complete a defined number of hours of continuing education / continuing professional development within their clinical area of prescribing practice to ensure currency of knowledge and skills.

Proposed list of prescription medicines for specialist nurse prescribing

The list contains commonly used medicines for common condition and is not an inclusive list. Please note the prescription medicines for community nurse prescribing on page 40 of the consultation document will also be included in the list for specialist nurse prescribers.

The Council is considering whether it is necessary to identify some medicines that specialist nurses may not initiate but could safely repeat prescribe. For example antipsychotic medicines.
2.14 Do the indicative community nurse prescribing and specialist nurse prescribing lists of prescription medicines reflect the range of medicines that nurses with specialist nurse prescribing rights will need to access?

Yes [ ] No [ ]

2.15 Do the prescription medicine lists include any medicines that specialist nurse prescribers should not be able to access?

Yes [ ] No [ ]

The indicative list does not distinguish between initiation of therapy with the medication or continuation of prescribing initiated by an authorised prescriber. In some circumstances we could see a benefit in “specialist nurse prescribers” being able to undertake ‘continuation prescribing’ of prescriptions initiated by an authorised prescriber at a general practice level with certain guidance in place. This could be achieved, for example, by a delegated prescribing order.

For example, the consultation states “Medicines for some common mental health conditions have been included as 50 to 70% of mental health disorders are managed by general practice. Demand is expected to double by 2020.” The Society believes that this is an area of clinical practice requiring specialist knowledge and disagrees with their inclusion for prescribing. Similarly antiarrhythmics, anticoagulants, disease modifying antirheumatic agents and antiepileptics all require advanced specialised knowledge beyond the scope of what is described for a ‘specialist nurse prescriber’.

2.16 Do you think there are medicines that specialist nurses should not initiate but could safely repeat prescribe?

Yes [ ] No [ ]

See above

Non prescription medicines

Non prescription medicines will not be included in the regulation but patients may be able to access a subsidy if the item is “prescribed” by a nurse with specialist nurse prescribing authority.

2.17 Do you agree that specialist nurse prescribers should be able to access the list of non prescription medicines on page 43 of the consultation document?

Yes [ ] No [ ]

However The Society would like to note that Gee’s Linctus is a medication with a potential for abuse due to it’s low concentration of morphine. We believe this should be excluded.
List of Controlled drugs for specialist nurse prescribing

Designated nurse prescribers are already able to prescribe from a list of 42 controlled drugs outlined in the Misuse of Drugs Regulation 1977 (see Appendix 7 on page 71 of the consultation document). The Council believes that some of the controlled drugs on the present list are no longer used or fall outside the therapeutic areas it has identified for specialist nurse prescribers. It is proposing a list of 15 controlled drugs for specialist nurse prescribing (see page 44).

Designated nurse prescribers are restricted to prescribing controlled drugs only for patients under their care, only in an emergency and only a 3 day supply (Misuse of Drugs Regulation 1977 Section 21 (4B)).

2.18 Do you agree with the proposed list of controlled drugs that nurses with specialist nurse prescribing rights will be able to prescribe as designated prescribers?

Yes ☒ No ☐

The list is largely appropriate.

2.19 Do you think that specialist nurse prescribers should be able to prescribe controlled drugs (from the appropriate list) for a period longer than three days?

Yes ☐ No ☒

The very nature of these medicines means they are prone to inappropriate use, abuse and or dependence; authorised prescribers are often pressured to prescribe these medicines. Therefore treatment periods longer than 3 days should be prescribed and monitored by an authorised prescriber (including nurse practitioners).

Other comments

3.1 Do you have any other comments on the consultation paper or the proposed models of nurse prescribing?

The Pharmaceutical Society supports the widening of non-medical prescribing including by our nursing colleagues.

However, we believe the coming changes in the Medicines Amendment Bill 2011 will address many of the concerns expressed in the consultation document particularly related to supply of medicines under standing orders and the described “prescribing by proxy”. The ‘Delegated Prescriber’ and ‘Delegated Prescribing Order’ expected to become authorised in the Bill covers these situations where a patient meets a predefined set of clinical criteria and does not necessarily need to be further assessed by the authorised prescriber; OR continuation prescribing could be permitted. The authorised prescriber assumes overall responsibility for the patient, however the role of the
delegated prescriber can improve timely access to medicines when the prescribing need is straightforward or a continuation prescription is all that is needed.

We believe increasing nurse prescribing to three different levels will create confusion and there will be uncertainty about what each can prescribe. For the dispensing pharmacist, multiple prescriber types present challenges as they assess the legitimacy of the prescription and appropriateness of drug choice where applicable (eg. according to the pharmacy medication history records).

We support having lists on the Nursing Council website of the medicines in each prescribing category and the nurses authorised from each list. Dispensing pharmacists will most likely search this information by looking up the prescriber name and which prescriber category they belong to – before checking what is prescribed against the appropriate list of medicines. We would strongly encourage the Nursing Council to make such information clear and searching simple and effective.

Many of the proposed medicines for prescription are available to purchase at retail outlets and pharmacies are not necessarily funded. Therefore having a prescription written for such medicines does not necessarily provide benefits in accessibility to medicines when they would have to take a prescription to a pharmacy anyway. Furthermore, if the medicine is not subsidised, a pharmacist is more likely to sell the medicine directly rather than dispense it according to the prescription – which would attract a dispensing fee on top of the retail price.

We are concerned that the level of training proposed for the specialist nurse prescriber does not meet the competence standards required and hence the requirement for safe, effective and competent prescribing.

While supportive of widening prescribing to non-medical prescribers, the Pharmaceutical Society is concerned increasing numbers of prescriber types being developed in isolation leading to different expectations with respect to prescribing competencies; which theoretically should be the same for any prescriber.

We would encourage the Nursing Council and all regulatory authorities of health professionals with prescribing rights to note the work of the National Prescribing Centre in the UK (see http://www.npc.nhs.uk/improving_safety/improving_quality/index.php) and similar around the world looking at a single competency framework for all prescribers. Separate entry criteria including further clinical postgraduate study can then be set for the various health professions according to practice requirements.

We would also like to draw to the Council’s attention the article ‘The competent prescriber: 12 core competencies for safe prescribing’ published in Australian Prescriber in February this year (Aust Prescr 2013;36:13–6. Available online at: www.australianprescriber.com/magazine/36/1/13/6). The article describes twelve Core Competencies of Prescribing which we believe describe the types of competencies any prescriber should have – regardless of scope, area of practice or degree of autonomy. The twelve core competencies outlined are:

1. Take and/or review medical history
2. Take and/or review medication history and reconcile this with medical history
3. Undertake further physical examination/ investigations where appropriate
4. Assess adherence to current and past medication and risk factors for non-adherence
5. Identify key health and/or medication related issues with the patient, including making or reviewing the diagnosis
6. Determine how well disease and symptoms are managed/controlled
7. Determine whether current symptoms are modifiable by symptomatic treatment or disease modifying treatment
9. Select drug, form, route, dose, frequency, duration of treatment
10. Communicate prescribing decision in an ambulatory care setting
11. Communicate prescribing decision in an inpatient setting
12. Review control of symptoms and signs, adherence, patient’s outcomes

The Australian Prescriber article notes that these competencies and further 4 stages of prescribing are underpinned by two extra elements – enabling knowledge, particularly clinical pharmacology, and global attributes such as self-reflection on prescribing.