Analysis of Submissions

Consultation: Two proposals for registered nurse prescribing

October 2013
## Contents

2 Foreword...................................................................................................................... 3

3 Summary ......................................................................................................................... 5

4 Introduction ...................................................................................................................... 10

5 Proposal One: Community nurse prescribing ................................................................. 13

5.1 Proposal for community nurse prescribing (Questions 1.1 and 1.2) .............................. 13

5.2 Title for community nurse prescribing (Question 1.3). .................................................. 29

5.3 Scope of practice and authorisation for community nurse prescribing (Question 1.4) .... 33

5.4 Qualification and training for community nurse prescribing (Question 1.5).................... 35

5.5 Standards and competencies for community nurse prescribing (Questions 1.6 and 1.7) ......... 44

5.6 Entry criteria for courses leading to community nurse prescribing (Question 1.8) .......... 46

5.7 Continuing competence and monitoring for community nurse prescribing (Question 1.9) .... 50

5.8 Prescription medicines list for community nurse prescribing (Question 1.10) ............... 54

5.9 Non-prescription medicines (Question 1.11) .................................................................. 65

6 Proposal Two: Specialist nurse prescribing .................................................................... 69

6.1 Proposal for specialist nurse prescribing (Questions 2.1 and 2.2) ................................. 69

6.2 Title for specialist nurse prescribing (Question 2.3) .................................................... 73

6.3 Work as part of a collaborative, multidisciplinary team (Question 2.4) ......................... 76

6.4 Practise under supervision for six months (Question 2.5) ........................................... 78

6.5 Scope of practice for specialist nurse prescribing (Question 2.6) ................................. 82

6.6 Wording of the specialist nurse prescriber scope of practice (Question 2.7) ................. 87

6.7 Additional wording in the registered nurse scope of practice (Question 2.8) ............... 88

6.8 Qualification and training for specialist nurse prescribing (Question 2.9) .................... 90

6.9 Standards and competencies for specialist nurse prescribing (Questions 2.10 and 2.11) ...... 93

6.10 Entry criteria for specialist nurse prescribing programmes (Question 2.12) ............... 95

6.11 Continuing competence and monitoring (Question 2.13) ......................................... 98

6.12 Proposed list of prescription medicines for specialist nurse prescribing (Question 2.14) .... 102

6.13 Prescription medicines nurses should not be able to access (Question 2.15) ............... 106

6.14 Prescription medicines specified for repeat prescribing (Question 2.16) .................... 108

6.15 Non-prescription medicines (Question 2.17) ................................................................ 110

6.16 List of controlled drugs for specialist nurse prescribing (Question 2.18) .................... 111

6.17 Conditions for prescribing controlled drugs (Question 2.19) .................................... 115

7 Other comments .............................................................................................................. 118
<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Appendix 1: List of submitters</td>
<td>123</td>
</tr>
<tr>
<td>2</td>
<td>Appendix 2: Responses to consultation questions</td>
<td>128</td>
</tr>
</tbody>
</table>
2 Foreword

The Nursing Council appreciates the feedback it has received to its proposals on registered nurse prescribing. There was strong support from submitters for both the community nurse prescribing and the specialist nurse prescribing proposals, and helpful feedback on areas where the proposals could be improved.

These proposals were primarily directed towards primary health care as an area in which nurse prescribing could make a difference to the increasing demand for health services and to inequitable access to health services. Some responses identified structural and funding barriers that will not necessarily allow nurse prescribers to deliver free or low-cost health care or medicines to patients. This contrasts with secondary services where there is no cost to the patient of seeing a specialist nurse who will be able to prescribe.

There was strong agreement that the community nurse prescriber proposal could enhance patient access and care, but there were concerns expressed about the length of the education and training proposed. There were also issues related to the variable support mechanisms (for example, nursing leadership, mentorship, case review, audit and continuing education) available across primary health care to support nurse prescribing and fragmentation of care between different health providers which could be exacerbated by more prescribers.

Patients who access nursing services (district nursing, home care, public health, school nursing, community mental health) often have low socio-economic status and often find it difficult to access other services because of cost, transport or lack of understanding of health. Nurses in these services are generally unable to access easy mechanisms to help patients to get the medicines they need. Some nurses in general practice are able to use standing orders and the Practitioner Supply Order to enable access.

The feedback on the list of medicines has identified that the inability to specify strength, route or any other circumstances related to prescribing a medicine (issues related to the Medicines Act and Regulations) could be a barrier to developing an appropriate, clear and understandable list of medicines for limited prescribing.

Submitters also revealed variability in the use of standing orders\(^1\). Originally standing orders were introduced for emergency situations in hospitals but since legislation was passed in 2002 they have been increasingly used “to extend the work of primary health care team members” (Scott-Jones and Lawrenson, 2008\(^2\)). Their use depends on the doctors involved in each practice and there is a lack of consistency in their implementation and in the education to support their use. Nurse prescribing is viewed by the Council and some

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\(^1\) A standing order is a written instruction issued by a medical practitioner or dentist. It authorises a specified person or class of people (e.g., paramedics, registered nurses) who do not have prescribing rights to administer and/or supply specified medicines and some controlled drugs. The intention is for standing orders to be used to improve patients’ timely access to medicines; for example, by authorising a paramedic in an emergency or a registered nurse in a primary health care setting. Ministry of Health (2012), Standing Order Guidelines. Wellington.

submitters as a way of ensuring nurses have the appropriate skills and experience for the prescribing decisions they make, and to reduce the variability of present standing orders practice. Prescribing by proxy appears to be a practice that many consider to be the same as working under standing orders. However, it is not clear if all nurses (and doctors) understand their accountabilities under these dependent ‘prescribing’ models. It is interesting that some submitters appeared happy for nurses to ‘prescribe’ medicines under these methods without qualifications but they were very cautious of nurses legitimately prescribing the same medicines (and taking full accountability for that decision) as designated prescribers.

There was a high level of support for the specialist nurse prescribing proposal and it is likely that it could be readily implemented into secondary services and build on the existing postgraduate education programmes. Specialist nurse prescribing’s introduction into primary health care could be limited by the same barriers identified under the community nurse proposal. Many nurses have already achieved qualifications to become nurse practitioners but have not been able to overcome the barriers to this role. The Council will therefore carefully consider the feedback it has received and will undertake further work to enhance these proposals and promote the appropriate supports before making an application for registered nurse prescribing. Achieving prescribing authority under the Medicines Act will not necessarily lead to benefits for New Zealanders unless this change is well supported by policy, funding, employers and medical mentors.

It is great to see Nursing Council leading this piece of work. I do however think, based on my experience to date, that to make nurse prescribing a noticeable reality in terms of numbers of RNs actually prescribing, at least in the secondary care services, there is going to have to be a significant shift of willingness and thinking on behalf of service managers, funders and our medical colleagues to support and enable it to happen. This may be similar to the challenges potential Nurse Practitioners (NPs) have faced and is evidenced by the relatively low NP numbers in New Zealand. This is despite the NP initiative being launched over a decade ago. The situation is not indicative of a lack of willingness or preparation from nurses to engage in the process, but rather the almost impenetrable barriers and hurdles that are in the way of nurses to actually make it a reality (84, Individual Nurse).

Our experiences of developing the regulatory and educational frameworks for prescriptive authority for nurses and midwives in Ireland revealed the need to continually promote and support the clinical governance structures in the practice setting for safe competent nurse prescribers. This has been accomplished by multidisciplinary and stakeholder input in programme development and health service provider policy for nurse prescribing (53, Nursing and Midwifery Board of Ireland).

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3 The nurse assesses the patient and makes a prescribing decision but the doctor signs the prescription.
4 Designated prescriber means a “person who belongs to a class of registered health professionals authorised by regulations to prescribe prescription medicines; and satisfies any applicable requirement relating to competency, qualifications, or training specified in or imposed under regulations”. Medicines Act (1981).
3 Summary

Between February and April 2013 the Council consulted on two proposals for registered nurses prescribing. This document summarises the responses from the 197 written submissions received. There was strong overall support for the Council’s proposals and the extension of nurse prescribing. There was less agreement and divergent views regarding some areas within both proposals, particularly the lists of prescription medicines but also the proposed qualification and training for community nurse prescribing. The responses are summarised under the two proposals below.

Very much welcome this advancement of clinical nursing practice that is going to support nurses to practice to the top of their scope of practice while enabling closer to home health care for the population. The framework suggested, supported by international evidence already notes a familiarity to frameworks existing. This expansion of the scope of practice for nurses brings a ‘fresh air’ approach to nursing after many years of debate and aligns nursing in NZ with contemporary practice in other Western countries. With the current drive to integration, prescribing for nurses would be a strong enabler (49, Kimi Hauora Wairau Marlborough Primary Health Organisation).

The two levels of RN prescriber within the designated class of prescriber is a pragmatic solution to the goals of improving access, timeliness and convenience to health services. While there are many nurses who would already meet the educational requirements to prescribe as specialist prescribers, there are fewer, particularly in primary care, with this level of education. The community prescribing role can be implemented relatively quickly (assuming appropriate courses can be offered and approved) and will have the added advantage of offering nurses in primary care an entree into postgraduate education (121, Massey University).

Thank you for the work you are doing on this. Health Reporoa in particular stands to benefit greatly from this if it goes ahead, ultimately for the benefit of our patients (170, Health Reporoa).

3.1.1 Community nurse prescribing

The Council proposed that suitably qualified and experienced registered nurses working in community and outpatient settings be able to prescribe a limited list of medicines to treat minor ailments and infections, and to promote health to some patients. The Council proposed that community nurse prescribing could be included in the registered nurse scope of practice and be regulated by the Council using an authorisation or condition on the scope of practice. The Council proposed an education programme of six days with three days of prescribing practice with a medical mentor.

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Schools, general practice, public health, Maori and Pacific Health providers, services for youth, family planning and other ambulatory services.
3.1.2 Support for proposal

The majority of submitters (90.2%) supported the community nurse prescribing proposal and agreed that community nurse prescribing will enable patients to receive more accessible, timely and convenient care (91%). Submitters commented on the benefits to patients in community settings but particularly patients who used nursing services, e.g. home care, district nursing, school nurses. Issues related to the extensive use of standing orders and the Practitioner Supply Order (stock of medicines) as a means of enabling patients to get the medicines they need were raised. Some submitters wanted the model to be more collaborative. A small number of submitters did not support the proposal. Some submitters, including most medical groups, supported nurse prescribing under a delegated model not as designated prescribers. Some submitters raised concerns about the lack of clinical governance mechanisms to support nurse prescribing in primary health.

3.1.3 Title and authorisation in scope of practice

Most submitters (71.6%) did not support the title for community nurse prescribing. It was considered by some to be confusing and limiting. Alternative suggestions included using ‘primary health’ in the title or registered nurse prescriber - level 1. Most submitters (74.7%) agreed 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. A smaller number of submitters suggested another scope of practice was appropriate or suggested wording changes.

3.1.4 Education and training

A minority of submitters (38.7%) agreed with the proposed education and training for community nurse prescribing. The reasons given for not supporting the qualification and training were that it was insufficient and the list of medicines was too extensive. Some thought the education should be at a postgraduate level. A small number of submitters did not support the qualification as they did not support this proposal. There was stronger support from submitters for the proposed programme standards (47.5%) and competencies (60.2%). Some submitters supported the qualification or suggested tailoring the education to specific medicines nurses would prescribe in some areas of practice. Most submitters (62.2%) supported the entry criteria for community nurse prescribing courses. A significant minority were concerned that the years of experience before entry to the prescribing course were insufficient. Most submitters (71%) agreed with the continuing competence requirements for community nurse prescribers.

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6 **Practitioner’s Supply Order** means a written order made by a Practitioner on a form supplied by the Ministry of Health, or approved by the Ministry of Health, for the supply of Community Pharmaceuticals to the Practitioner, which the Practitioner requires to ensure medical supplies are available for emergency use, teaching and demonstration purposes, and for provision to certain patient groups where individual prescription is not practicable.


7 The Medicines Amendment Bill will establish a new category of delegated prescriber, whose members will be allowed to prescribe under a delegated prescribing order issued by an authorised prescriber.
3.1.5 Medicines lists

Submitters were equally divided in their response to the proposed list of prescription medicines with approximately half (49.6%) agreeing with the list and half (49.6%) disagreeing with the proposed list for community nurse prescribers. Some submitters supported the breadth of the lists and saw this proposal as being safer for the public than the variable education of nurses presently using standing orders. Many submitters commented on the list of prescription medicines being too extensive, not reflecting the intention of addressing minor ailments, containing too many medicines in relation to the length of the course, and including PHARMAC-restricted medicines, antibiotics and other inappropriate medicines. Suggestions were made to clarify the route of administration, specify repeat prescribing for some items and develop focused lists for specific areas.

A large majority of submitters (85%) agreed that community nurse prescribers should be able to access the proposed list of non-prescription medicines.

3.1.6 Specialist nurse prescribing

<table>
<thead>
<tr>
<th>The Council proposed 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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Council proposed two options as to how it could regulate specialist nurse prescribing using the scopes of practice provisions under the Health Practitioner Competence Assurance Act, 2003 (the Act). 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 in a registered nurse’s scope of practice.</td>
</tr>
<tr>
<td>The Council proposed that specialist nurse prescribers complete a postgraduate diploma in specialist nurse prescribing. The programme proposed includes 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.</td>
</tr>
</tbody>
</table>

3.1.7 Support for the proposal

A large majority of submitters (93.6%) agreed with the proposal that suitably qualified and experienced registered nurses be able to prescribe from the specialist and community nurse prescribing lists of medicines. The majority of submitters (94.3%) agreed that specialist nurse prescribing will enable patients to receive more accessible, timely and convenient care. Some medical and pharmacy groups would prefer to see a model of delegated prescribing. Some medical groups gave support to specialist nurse prescribing under designated prescriber.

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8 Under section 22 of the Act, the Council may change a scope of practice and state the health services a nurse is able to perform.
3.1.8 Title

About half of submitters (50.8%) supported the title ‘specialist nurse prescribing’. Some submitters thought the title would be too confusing especially with clinical nurse specialist and specialty nurse roles. Others thought the title was confusing or misleading because it implied the nurse would be working in a specialist area. Some suggested titles were to add the nurse’s speciality to the title or use registered nurse prescriber - level 2.

3.1.9 Collaboration and supervision

Nearly all submitters (94.2%) agreed that nurses with specialist nurse prescribing authority should be required to work in a collaborative multidisciplinary team. Most submitters (91.6%) supported nurses with specialist nurse prescribing authority being required to practice under supervision for six months from when they begin to prescribe.

3.1.10 Scope of practice or authorisation

A minority of submitters (38%) supported specialist nurse prescribers being registered in a new scope of practice. Most submitters (64.9%) agreed with the wording of the scope statement proposed if nurses with specialist nurse prescribing authority were to be registered in a separate scope of practice. Most submitters (76.8%) agreed with the proposed wording to be added to the registered nurse scope of practice if specialist nurse prescribing authority is indicated by an authorisation/condition. Most submitters (62%) agreed with an authorisation/condition being included in the registered nurse scope of practice.

3.1.11 Education and training

A strong majority of submitters (90.5%) agreed with the proposed education and training for specialist nurse prescribing. Most submitters agreed with the proposed standards for programmes (92.2%) and competencies (94.6%) for specialist nurse prescribing. Many submitters were concerned that there needs to be a pathway for nurses who have already gained a master’s degree or completed similar papers. Other submitters suggested broadening the mentor definition to include nurse practitioners and to include common mental health conditions in the programme. The majority of submitters (66.2%) agreed with the entry criteria for specialist nurse prescribing programmes. Again a minority of submitters wanted more clinical experience in the prescribing specialty as a criteria for entry to the programme. A strong majority of submitters (81.3%) agreed with the continuing competence requirements for specialist nurse prescribers.

3.1.12 Medicines lists

Most submitters (62.3%) agreed with the list of prescription medicines for specialist nurse prescribing. Some submitters were concerned that the list was too extensive and should be restricted or formulated according to area of practice or specialty lists. A minority of submitters (26.5%) wanted medicines removed from the list. Other submitters (74.1%) agreed that some medicines might not be initiated but could be repeat prescribed. Nearly all submitters (98.2%) agreed that specialist nurse prescribers should be able to access the list of non-prescription medicines. Most submitters (81.8%) agreed with the proposed list of
controlled drugs. Just over half of submitters (56.1%) agreed with specialist nurse prescribers being able to prescribe controlled drugs for a period longer than three days.
4 Introduction

Between February and April 2013 the Council consulted on two proposals for registered nurses prescribing. The consultation document was sent to 610 organisations and individuals from across the health sector. This paper summarises the written submissions received. A consultation questionnaire was developed to assist submitters to provide feedback on the two proposals.

4.1.1 Analysis of submitters

A total of 197 written submissions were received. There were 94 submissions from organisations, 36 from groups and 67 individual submissions. A list of the organisations and groups making submissions is in Appendix 1. The total number of submissions and the number of individual and group submissions shows a high level of interest in this consultation\(^9\).

Submissions were made from health professionals in a wide range of health services and specialty areas. Responses were received from medical, pharmacy and nursing groups and organisations. Nine individual and group submissions were received from nurse practitioners and 18 from clinical nurse specialists.

<table>
<thead>
<tr>
<th>Type of respondent</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual nurses</td>
<td>49</td>
</tr>
<tr>
<td>Groups of nurses</td>
<td>35</td>
</tr>
<tr>
<td>Individual doctors</td>
<td>9</td>
</tr>
<tr>
<td>Individual nurse practitioners</td>
<td>5</td>
</tr>
<tr>
<td>Individual pharmacists</td>
<td>4</td>
</tr>
<tr>
<td>Groups of pharmacists</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>103</td>
</tr>
</tbody>
</table>

\(^9\) The Council consulted on the Code of Conduct in 2011-2012 and received 73 written submissions. Of these 39 were from organisations or groups and 34 from individuals.
Table 2: Types of organisational submitters

<table>
<thead>
<tr>
<th>Type of respondent</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Health Boards</td>
<td>13</td>
</tr>
<tr>
<td>Professional organisations (nursing)</td>
<td>13</td>
</tr>
<tr>
<td>Non-governmental organisations – health providers</td>
<td>10</td>
</tr>
<tr>
<td>Primary health organisations (PHOs)</td>
<td>10</td>
</tr>
<tr>
<td>Education providers</td>
<td>9</td>
</tr>
<tr>
<td>Professional organisations (medicine)</td>
<td>7</td>
</tr>
<tr>
<td>Primary health providers (other)</td>
<td>7</td>
</tr>
<tr>
<td>Professional organisations (specialty groups)</td>
<td>7</td>
</tr>
<tr>
<td>Professional organisations (pharmacist)</td>
<td>5</td>
</tr>
<tr>
<td>Regulatory authorities</td>
<td>4</td>
</tr>
<tr>
<td>Consumer groups</td>
<td>3</td>
</tr>
<tr>
<td>Government agencies</td>
<td>3</td>
</tr>
<tr>
<td>Other organisations</td>
<td>2</td>
</tr>
<tr>
<td>Aged care providers</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total number of submissions</strong></td>
<td><strong>94</strong></td>
</tr>
</tbody>
</table>

Submitters were assigned to a practice area based on the information they supplied. The proportion from each practice setting or specialty is shown in Chart 1 on the following page.

Several submissions were made by nursing groups that spanned both District Health Boards’ ‘primary’ services and other services provided in a primary setting. These have been categorised as primary.

District Health Board has been used as the category when the submission represented the whole DHB or when the submitter did not specify an area of practice except for DHB.

Chart 1 shows that a wide range of clinical settings and specialty areas were represented in the submissions.
Other includes cancer, anaesthesiology, colorectal, immunisation, gastroenterology, aged care, prison, defence, dermatology, ear, neonatal, outpatients, private surgical, renal and rheumatology.

4.1.2 Analysis of submissions

The comments made by submitters have been analysed and are presented in themes under the proposal questions. Quotes have been selected to illustrate these themes. A list of submitting organisations and assigned number can be found in Appendix 1. Other issues raised by submitters are discussed in the last section.

Seven medical organisations responded to the consultation. They did not answer the yes/no questions so could not be included in this data, but their comments have been included in the general analysis.
5 Proposal One: Community nurse prescribing

5.1 Proposal for community nurse prescribing (Questions 1.1 and 1.2)

The Council proposed that suitably qualified and experienced registered nurses working in community and outpatient settings be able to prescribe a limited list of medicines to treat minor ailments and infections, and to promote health to some patients. The ability to prescribe a limited number of medicines would enhance the health services registered nurses are able to deliver.

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.

The majority of submitters supported the community nurse prescribing proposal (90.2%) and agreed that community nurse prescribing will enable patients to receive more accessible, timely and convenient care (91%) (see Chart 2 below).

Chart 2: Support for community nurse prescribing proposal

Submitters commented on the benefits of the proposal to patients in all community settings with it being particularly beneficial to patients of non-governmental organisations and

10 Schools, general practice, public health, Māori and Pacific Health providers, services for youth, family planning and other ambulatory services.

11 A table with the number of responses to each question can be found in Appendix 2.
services outside of general practice, e.g. home care, district nursing, public health. Issues related to the extensive use of standing orders and the Practitioner Supply Order (stock of medicines) as a means of enabling patients to get the medicines they need were raised. Submitters commented on the proposed education and medication list, and these themes are discussed under sections 5.4 and 5.8. Some submitters wanted the model to be more collaborative. A small number of submitters did not support the proposal because they considered it to be unsafe or they believed having three levels of nurse prescriber would be too confusing.

5.1.1 Benefits to patients

Many submitters made comments that supported the proposal identifying benefits for patients in terms of timely treatment, reducing costs and saving patients’ time (12, 14, 21, 27, 28, 32, 33, 34, 37, 38, 49, 54, 55, 59, 61, 75, 76, 77, 78, 87, 94, 96, 105, 124, 153, 156, 157, 159, 162, 166, 183).

This will provide flexibility to services and increase access to patients reinforcing the message the patients’ time is also valuable and has a financial perspective attached to it (49, Kimi Hauora Wairau Marlborough Primary Health Organisation).

It makes sense to give clients prescriptions at time of visit, no delays or non-compliance or issues of neglect due to high costs of GP visits, which is often cost prohibitive to many families and beneficiaries. Often families owe money at the GP so won’t go. Time efficiency for staff, not having to try and organise GP vouchers for minor problems e.g. impetigo, scabies etc. An example from my practice is where a large family of 10 children, a few of the children had scabies. The GP would not give enough treatment for the whole family without seeing most of them. This increased not only costs but extra stress and encouraged non-compliance therefore increased the spread of scabies in the community (105, Individual Nurse).

This proposal would allow for immediate and timely treatment as research shows that young people especially often do not present to general practice due to a number of barriers. Helps with costs, particularly for those clients not engaged with local primary care providers. School nurses provide an easily accessible, affordable service – no charge to see the school nurse which makes it appealing to young people and their family/whanau (156, CMDHB School Health Awareness Raising Group (SHARP)).

A client newly diagnosed with infectious tuberculosis was discharged home on antibiotics. He reported to the Public Health Nurse he had a sore mouth and was finding it difficult to eat or drink, the nurse visited (20 minute drive one way) and assessed he had oral thrush. An appointment was made with the GP (40 minute drive return); he had to wait outside and was seen in the car as he was infectious. He was prescribed oral mycostatin (37, Individual Nurse).
5.1.2 Benefits to the patients who use nursing services in the community

Submissions from providers of non-governmental organisation nursing services or other nursing services indicated the proposal would be beneficial to their patients who often had difficulty accessing general practice easily because of disability, transport, time and cost-related issues. For some patients nurses are their primary health providers in the community and the ability of nurses to prescribe for minor ailments would reduce these difficulties. Some of these services do not include a doctor and therefore there is no access to standing orders or the PSO (practitioner supply order) stock of medicines. Areas specifically mentioned as benefiting from this level of prescribing authority were home care (for the elderly and disabled) (124), public health (136), schools (4, 41, 55, 156), prisons (8, 40, 147), well child and child health (19, 41, 147, 157, 158) and district nursing (53, 124). Other groups suggested for inclusion within the proposal were lactation consultants, midwives who are also RNs, B4 school check nurses and well child providers (158).

Different community nurses work in different community settings. Some may have a doctor/NP onsite to delegate prescribing rights however some do not have any GP/NP to delegate prescribing rights (102, Individual Nurse).

On behalf of the group that we represent we are already working in a community based nurse led clinic using standing orders and getting clinical oversight from a GP at the practice that holds our funding contract and would find working under either of these proposals very beneficial to our current work setting (18, Group of Nurses).

Prison nurses
Current constraints of initiating medication outside of Medical Officers visits and Standing orders could be greatly diminished (40, Department of Corrections Health Services).

Public health nurses
This would definitely support the Primary Health Care Strategy and would strengthen the “Better Sooner More Convenient” goal of early access to Primary Health Care services. The communities in which the Public Health Nursing (PHN) team predominantly work, are vulnerable, high needs communities who often have multiple barriers to accessing primary health care services. Having suitably qualified and experienced PHNs who are able to prescribe medicines for minor infections will provide increased access to primary health care and most importantly, early intervention and treatment (136, Group of Nurses, Public Health).

Nurses in our sector are often frustrated by the process that is required for clients to access medications for straightforward ailments.

Aged care / Home Care
In home care most of our clients are over 80. Many have limited mobility even around their own home. They receive a small amount of home support, and may receive nursing support following a hospital admission.

Many live with both chronic conditions that can result in hospital admissions and minor conditions that can progress to hospital treatment if left unattended.
Medical care is provided via the primary health provider (doctor) or via district nursing services. Some have lost contact with their primary health provider when they move into smaller premises, into a retirement village, or to be closer to family members. The nurse from the home care provider and the support workers become integral to the maintenance of their health.

It is not envisaged that Registered Nurses working in Home Care would prescribe for clients with complex medical conditions or for those on multiple medications unless they were working collaboratively and in agreement with the client’s GP. However the provision of a limited range of medicines that provide relief from minor ailments from an agreed formulary by an RN who has the necessary knowledge and certification would provide improved access to care for a wide range of people living in the community.

District nursing

Registered Nurses in District Nursing work with clients with a range of health problems from simple to very complex. RN prescribers would most likely prescribe for simple ailments from the formulary for clients with non-complex needs.

Providers that hold district nursing and ACC community nursing contracts are trained and skilled to provide a range of nursing services, and their experience is very broad.

Injury related care

In injury related care, again, clients are often less ambulatory, in both short term and serious injury cases and may not have natural supports. Some patients may be too frail to drive themselves or use public transport. ACC contracts Nursing Services for services previously described as Community nursing, Serious Injury and Rural nursing.

NZHHA considers that extending the prescribing ability for nurses providing services under an ACC nursing contract would further enhance client recovery, access to treatment, and understanding of self-care.

…An example of a serious injury case that is not uncommon. A client who lives at home with a serious spinal injury may have an issue that is recurrent as a result of their inability to swallow, to move easily or to have independent use of their bowel. In order to receive a medication which quickly addresses minor recurrent issues the client must be transported from home to the doctor, a technically difficult journey and one that could be avoided if an appropriately trained and competent nurse was able to prescribe for the client (124, New Zealand Home Health Association Inc.).

School nurses

For young people engaged in secondary schools, School Based Health Centres (SBHC) are often the first point of contact. School Nurses have an established and trusted relationship with students and whanau, often up to 5 years. Students are often sent by families and school staff for screening by the school nurse prior to making an appointment with their GP. As the nurses provide an onsite service there is no transport required. If GP is required, the RN will ensure the student is referred. Often parents are unable to get time off work to take students to appointments within current GP hours (156, CMDHB School Health Awareness Raising Group (SHARP)).
As school nurses, parents often send students to us to ask if whatever ails them requires GP assessment (time/ money constraints). For minor thing it would be helpful to be able to help them directly (4, Individual Nurse).

Nurses who are employed under education may not have the clinical support that is required – this may necessitate a restructure of the current employment model for school based nurses to be employed by health, e.g. in a locality framework (155, Auckland School Nurses Group).

5.1.3 Benefits for rural communities

There was particular support for benefits of nurse prescribing in rural areas (2, 3, 6, 41, 116, 158, 159, 168, 170, 189).

Rural Women New Zealand believes patients in rural environments, where there are low resources and access to medical care, will be the beneficiaries and recommends the extension for Registered Nurse prescribing with the appropriate training, support, and with regular evaluations in particular from the patient perspective (2, Rural Women New Zealand).

We are a Rural Nursing service located 40km from the nearest GP, so this would be an asset to our nurses and more importantly our patients, saving money and time (170, Health Reporoa).

Especially for RNs working in rural areas and for those working independently and able to treat minor ailments/infections e.g. school nurses (41, Primary Health Organisation).

5.1.4 The limitations of standing orders

Many nurses said they were using standing orders and the PSO (Practitioner Supply Order) stock of medicines to treat minor ailments, or prescribing by proxy (the nurse assesses the patient but the doctor signs the prescription), but they would prefer the authority to prescribe (19, 44, 47, 72, 81, 101, 109, 136, 137, 150, 164, 166, 172, 185, 187, 189).

Nurses can administer or supply medicines under standing orders but they cannot write a prescription to be filled at a community pharmacy. Nurses (and doctors) work around the existing system that prohibits nurses from prescribing by using the PSO stock of medicines to supply patients with medicines when they could be dispensed by a community pharmacist, or by using pre-signed prescriptions. Other submitters said they were doing it (community nurse prescribing) under standing orders anyway (10, 81, 162, 170, 181, 192) which may mean they are using prescribing by proxy as not all medicines listed are available.

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12 This practice is specifically cautioned against in the Ministry of Health, (2012), Standing Order Guidelines, Wellington.
on the PSO. Prescribing by proxy appears to be considered the same as or interchangeable with ‘working under standing orders’, by many nurses.

As mentioned in the consultation document, many nurses are prescribing by proxy. This opportunity supports nurses working to their highest possible capacity within the RN role, maximising the postgraduate study many RNs have done. This opportunity also assists in meeting the growing demand for medications, a growing population and the unavailability of accessing GP appointments (12, Individual Nurse).

Excellent development for nurses. PHN’s are working under a wide range of Standing Orders and by having PHN’s who are able to prescribe this would increase access and reduce potential hospital admissions for simple health issues; in particular for vulnerable communities i.e. Pacific Island and Maori families (136, Group of Nurses, Public Health).

Definitely. Right now I often get drs who have never seen the pt. (and also not seen them now) to sign a prescription (10, Individual Nurse).

Other submitters pointed out many of the inconsistencies related to standing orders. In some general practices they are not used at all and in others there are inconsistencies in how the training and competence assessment that nurses are required to undertake. These submitters agreed that qualified nurses with prescribing authority would be safer for patients (56, 81, 150, 189).

The College also notes that many of the medicines on the proposed list are currently supplied and administered to clients under standing orders. Education and competence assessment processes for standing order use by registered nurses are currently highly variable. We therefore consider that it would be safer for registered nurses to prescribe these medicines independently because of the standardised authorisation (education and competence) requirements (56, College of Nurses Aotearoa New Zealand).

Proposed concept is great, if adequate training is provided and as long as scope of medication list is reduced. Current environment sees the role of health professionals broadening and moving to nurse prescribing and provides a realistic opportunity for nurses. The development of clinical pathways will only grow over the coming year and allowing nurse prescribing certainly fits well with implementation of these pathways. Current practice is ad hoc with variable use of standing orders, with or without competencies, and bringing in nurse prescribing will bring a standard of practice into place. Much better for patient safety. Consideration will need to be given for transition from current standing order use to nurse prescribing (150, Compass Health).
Nurses at Auckland Sexual Health once they have passed the PDRP\textsuperscript{13} process to level 4 and have completed the standing order (SO) evaluation, currently work under standing orders, assessing, diagnosing and treating their own clients without medical consultation. Having prescribing rights will allow less administration work and the transferring of files for SO sign off, and less room for error with the tight time frames for SO sign off (81, Individual Nurse).

Improve the efficient delivery of treatment. For example, the current use of standing orders is not an efficient way of delivering treatment. Signing off standing orders is a time-consuming process for medical practitioners. Therefore, the options for a new scope of practice for specialist nurse prescribers, or an addition to the registered nurses’ scope of practice to allow specialist nurse authorised prescribing, represent opportunities to improve nurse-patient and nurse-doctor interactions and provide clear accountabilities for nurse prescribers (189, The Royal Australasian College of Physicians).

The Royal New Zealand College of General Practitioners supported increased guidance and consistency for standing orders.

The use of standing orders is another safe way of increasing access to medications in a team environment. These are already used to enable some nurses to supply and administer certain medicines as authorised by a doctor, particularly in rural areas. The College recognises that there are some frustrations with this process and the use of standing orders could benefit from increased guidance and consistency. It would make sense to review this area and develop a proper legal solution to the problem of medical staff not always being present (194, The Royal New Zealand College of General Practitioners).

5.1.5 Standing orders are used extensively in family planning and sexual health

Contraception and sexual health were areas highlighted as being appropriate for nurse prescribing with standing orders being used extensively.

The very high volume of medication provision by Family Planning nurses makes standing orders cumbersome and raises issues of how the client can get a prescription or how the clinics can carry large volumes of pills and other medications. Credentialing the nurses to do their own prescription is the answer (72, Family Planning).

\textsuperscript{13} Professional development and recognition programme (PDRP) is a competence based programme that assesses nursing practice against competencies, recognises level of practice and supports ongoing professional development.
Nurses at Auckland Sexual Health Service (ASHS) once they have passed the PDRP process to level 3/4 and have completed the standing order assessment, currently work under standing orders, assessing, diagnosing and treating their own clients without medical consultation. ASHS has excellent training processes following strict guidelines and protocols, it takes at least a year for new nurses to our service with no previous sexual health experience to start working at the basic SO level 3 on the PDRP and longer to reach level 4 PDRP (proficient) with no restrictions on using ASHS SO (81, Individual Nurse).

5.1.6 Standing orders are used to enable free access to medicines

Two submitters thought the proposal would mitigate some of the problems related to working under standing orders but would not address the benefits of using standing orders to access the PSO for patients who cannot afford the pharmaceutical surcharge or would not comply with the requirement to fill a prescription, e.g. cost, time, transport barriers or health literacy barriers, i.e. a lack of understanding of health and the potential for a condition to become more serious or cause complications without treatment (122, 156).

In principle – Yes – Outside general practice e.g. public health nurses, sexual health service clinics, youth health centres, school health clinics, well child/Tamariki Ora providers, family planning services etc.- ‘community’ prescribing will legitimise current practice (standing orders) and address the many work-arounds that are time consuming and in some circumstances not within the bounds of current legislation. ‘Community’ prescribing, however, won’t in all cases enable more timely, effective and convenient care for the patient (as many nurses working in these areas of practice are already working to standing orders). It will, however, be much more timely, effective and convenient for the nurse prescriber.

It is worthwhile remembering that currently (within general practice settings) one approach to nurses enabling patients to receive more accessible, timely and convenient care is through the use of the MPSO (medical practitioner supply order) via standing orders. Whilst not an entirely legitimate use of the MPSO it does mean that patients are supplied medicines on the spot according to need, the first dose can often be administered, education can be provided about both the medicine - and importantly storage - and there can be follow up with adherence. An unintended consequence (within general practice) of ‘community’ nurse prescribing might be that patients who are most in need of the prescribed medicine will not fill it at the pharmacy for the same reason they don’t fill prescriptions that are provided by GPs- cost being the barrier.

‘Community’ nurse prescribing may alleviate the cost issue for some patients and their family/whanau, as the cost of seeing a nurse, in most cases, is less than seeing a doctor (and in some cases free). If the goal for ‘community 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’ consideration needs to be given to free access to comprehensive primary health care services which should include– but currently does not) consultations (GP or RN) and pharmacy/ medicines. Many nurse-led primary health care services are already
either currently free or low cost (public health, WCTO, family planning, some Maori and Pacific, Youth Health, school etc.). Prescribing medicines on its own will not meet the goal – prescribing medicines that are free at the point of supply does (122, District Health Board).

However while this will improve access to a script, the fundamental block is that most of our families are not able to pay the $5 dispensing fee. Many of our schools are currently paying for some student’s scripts out of the school health budget.

Will this enable access to MPSO? School nurses need easy access to Postinor, salbutamol, panadol, condoms, pregnancy tests, spacers. This will enable follow up with students that scripts have been filled and taken as the RN will know what has been prescribed, where as now RN’s do not know what GPs have prescribed for students (156, CMDHB School Health Awareness Raising Group (SHARP)).

For nurses to be able to prescribe effectively particularly in high deprivation populations, they would need access to MPSO supplies (155, Auckland School Nurses Group).

5.1.7 Proposal does not address barriers to care

A few submitters were concerned that the proposal would not necessarily address some of the barriers to timely care and other options to address access should be considered (3, 61, 100). One submitter thought it would create unrealistic expectations rather than create opportunities to access and educate other family members.

No, I strongly disagree with the statement that it will allow more timely access to care. In general terms, this is simply putting a sticking plaster over the problem of insufficient access to doctors. Certainly the care will be provided and there is a lot to be said for it, however the cost is very high for the value provided and there is a danger of generating unhelpful expectations of healthcare in the long term. It is certainly inappropriate to be proposing a home visit to a child with impetigo. An afflicted family with multiple reinfections, perhaps, a single child, no (61, Individual Doctor).

Just have specialist nurse prescribing and NP level. Community prescribing level too low, will never address pt. cost and access issues and pt. safety (71, Group of Nurses, Primary Health).

5.1.8 Lack of pharmacist dispensing when using the PSO

The Pharmacy Council made the point that the PSO works in general practice but there is greater risk posed by lack of dispensing when medicines are supplied from the PSO stock (85).
The proposal also does not make clear the extent of separation between prescribing and supply or administration. As an example, it outlines how a nurse would be able to supply the emergency contraceptive pill, presumably by prescription and prescribe an ongoing oral contraceptive for the patient. This scenario gives rise to a number of issues including the lack of a “second pair of eyes” in the dispensing process, and therefore a potential conflict of interest. This was also emphasised as a potential conflict in the pharmacist prescriber model, by which those who raised it inferred that patient choice may be increased but it doesn’t always go hand in hand with patient safety (85, Pharmacy Council of New Zealand).

The Guild believes that the supply of medications by PSO should not be an option for either community or specialist nurse prescribers. Any prescribing must be on a Named Patient basis with the accountability that goes with it. From a community pharmacy perspective, it has been widely acknowledged for many years that the current level of prescribing training for all prescribers is inadequate and needs attention. Community pharmacists spend a great deal of their time each day clarifying prescriptions- from chasing up prescribers for information that has not been included on a prescription, to prescription errors, legal issues and funding requirements. All this involves time that could be better spent on patient care. Some of this spent time is due to software systems that have not been updated, but often it is a result of lack of prescriber knowledge on how to write a prescription. It is important prescribers have the ability to generate prescriptions electronically, as handwritten prescriptions are often handed to the pharmacist with legally required information missing (60, Pharmacy Guild of New Zealand).

5.1.9 Opposition to the model of prescribing

Fifteen submitters (8.6%) did not support the proposal. Some submitters did not support any further extension of nurse prescribing and thought it should be restricted to nurse practitioners only (23, 103, 195).

5.1.10 Support for specialist nurse prescribing only

Some submitters did not support three levels of prescribing but supported registered nurse prescribing similar to the proposed ‘specialist nurse prescribing’ (26, 36, 52, 63, 65, 125, 165). Other submitters commented that three levels of nurse prescribing would be confusing (60, 161, 175, 178, 180, 184, 192).
Not for a general community nurse. Yes for specialist nurse practitioners such as diabetes nurses, respiratory and heart failure nurses. It is a wide list of proposed medication, the level of understanding and usage of each medication appropriately in a community nurse who intends to be in a general field needs to be demonstrated to be at a satisfactory level (63, Individual Doctor).

… Providing patients with someone to prescribe is missing the point of limited access to care. Patients need comprehensive care not just prescriptions, and by training nurses, and broadening the scope of practice in just this one area we are offering a piecemeal approach to providing health care. By requiring those same nurses to work and study for advanced practice the opportunity is then there to provide many aspects of care and address the multiple facets of what is lacking in access to quality health care (125, Group of Nurse Practitioners).

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 (e.g. 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 (178, Pharmaceutical Society of New Zealand).

It is unacceptable to us that nurses prescribe without sufficient educational preparation. Nurses must have sufficient knowledge of research and evidence and understand complex pathophysiology in order to assess and diagnose appropriately before being able to prescribe safely. If nurses with a ‘short course’ can diagnose and prescribe it undermines the education, qualifications and professionalism of nurses with advanced levels of academic preparation. This is not acceptable for professional nursing practice.
Safe prescribing requires training in core skills, which are generic, whatever the prescribing “scope” (165, Victoria University of Wellington).

5.1.11 Use standing orders

Some submitters thought that standing orders would be safer than community nurse prescribing (57, 107, 148).

Although we agree that this proposal would enable patients to receive treatment in a more timely and accessible way we believe this could still be achieved through standing orders and that this is a safer option than the current proposal (57, District Health Board).
Standardised standing orders on a national basis may be a safer way of solving the issues around access to prescribing that the document is trying to address. This would also ensure that there are clear lines of responsibility around prescribing and mechanisms that ensure patient safety (107, Individual Pharmacist).

The scope for community nurse prescribing is very broad. Greater emphasis could be put on the national development of standing orders for nurses working in primary care, with robust support systems in place (116, Non Government Organisation).

5.1.12 Develop protocol prescribing

Another suggestion was to develop and use national protocols as the basis for this level of prescribing (148).

… National protocols or standing orders would also allow for supply of medicines. For example, a process similar to that which is already in place for RNs to provide emergency contraception may be more robust than having an open list of named medications. Obviously within the list supplied, not every medication would be required by every community nurse prescriber. Therefore a limited list based on clinical practice settings would be a more suitable framework for entry prescribers and to support this change of practice safely both for patients, prescribers and dispensers. As an example, a set of protocols for use by community ear nurses to provide antibiotics, antifungal and other medications commonly used within their practice (148, Government Agency).

5.1.13 Open up non-prescription subsidies

PHARMAC suggested another option may be to open up the subsidy to over-the-counter (OTC) medicines for nurses (181).

An alternative option for increasing nurse prescribing and improving access could be extending the restricted medicines (as opposed to prescription medicines) that nurses are able supply. The advantage to this option is that it restricts prescribing by indication, as well as by pharmaceutical (181, PHARMAC).

5.1.14 Delegated not designated prescribing

Other submitters supported nurse prescribing but under a delegated model of prescribing (60, 69, 114, 135, 148, 178, 186, 194). The model of delegated prescribing described by some is of a nurse having a relationship with a specific medical practitioner.
…We are unequivocally opposed to the proposals being advanced by the Nursing Council for independent designated community nurse prescribing and independent designated specialist nurse prescribing. We believe that these models of nurse prescribing could, if implemented, lead to serious adverse consequences for the health and safety of patients, undermine integrated collaborative healthcare teams, and have detrimental consequences for the wider health system in New Zealand. Our position should not be interpreted as one of blanket opposition to nurse prescribing. On the contrary, the NZMA has previously conveyed its support for non-medical prescribing that occurs within a delegated model. Our organisation would be supportive, in principle, with the extension of prescribing rights for suitably qualified nurses, provided that this occurs under a delegated model of prescribing (69, New Zealand Medical Association).

There was support for delegated prescribing within a collaborative multidisciplinary team environment led by the most qualified professional in the team, usually a medical practitioner. It is considered, from the information given, that this is the most appropriate model for community nurses (135, Council of Medical Colleges in New Zealand).

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 (178, Pharmaceutical Society of New Zealand).

A few submitters commented that it was not the role of nurses to diagnose or that nurses do not have the skills to diagnose (69, 186, 194).

We submit that the task of diagnosis and initiation of treatment of patients with all but the most common and simple conditions remains a medical role. The education in anatomy, physiology, diagnosis and therapeutics of medical training are attained over many years. We acknowledge that specialist nurses working in specialised areas (e.g., diabetes, respiratory, neonatal medicine) achieve comprehensive and detailed knowledge in their areas of expertise, but not across the broad spectrum of medicine (186, New Zealand Society of Anaesthetists).

5.1.15 Fragmentation of care and shared electronic records

Three medical groups expressed concern about the potential for nurse prescribing to fragment care (38, 69, 96, 114, 194). Others submitters were also concerned with the risk of fragmentation of care caused by multiple prescribers (98, 104, 140, 150, 181). Some
submitters thought prescribing should not be introduced until shared electronic records and e-prescribing are available (60, 69, 114, 135, 156, 179).

The availability of IT access is vital in the community setting re the RN extended prescribing roles to ensure collaborative, integrated health care provision and ensure communication to all health professionals. Access to key health information; will the community nurse have access to medical history, allergies, health information to make sound prescribing decisions and documentation of health care? The community nurse in GP setting has access to this information (38, Individual Nurse).

The NZMA is concerned that independent nurse prescribing may well lead to greater fragmentation of care as it facilitates independent practice occurring outside the multidisciplinary team. Many general practitioners have indicated that they already contend with less than ideal communication flows with hospital-based doctors. Medication regimens are often altered in hospital without adequate consideration of the patient’s broader circumstances and with minimal consultation with the general practitioner. The addition of independent nurse prescribers in the absence of a shared electronic health record could exacerbate issues relating to communication and collaboration (69, New Zealand Medical Association).

It is vital that any new class of prescribers is thoroughly integrated with the developing new e-health initiatives. These initiatives— in particular, e-prescribing and the electronic shared care record— would be vital for a new class of prescribers to be part of (60, Pharmacy Guild of New Zealand).

With the increase in prescribers across the sector there is an urgent need to facilitate e-patient records so that all prescribers can know what medicines the patient is already using and what other health professionals involved in the patients care are prescribing (135, Council of Medical Colleges in New Zealand).

Specifically in relation to the proposal for independent community nurse prescribing, the College is concerned that the proposals make no provision requiring nurses to work in collaboration or cooperation with others, and leaves open the clear danger of creating another set of health care providers offering services to patients without any reference to the ‘safe harbour’ of their registered general practice. Many GPs are already concerned that patients see pharmacists, physiotherapists and nurse practitioners to deal with their ‘simpler health problems’, leaving GPs to deal with more complex problems. This often results in patients presenting later without an integration of notes from the various practitioners who have seen them for separate matters. These concerns would be exacerbated with the introduction of independent community nurse prescribing. At the minimum, therefore, an independent community nurse prescriber category should not be established until the introduction of shared electronic records and e-prescribing (194, Royal New Zealand College of General Practitioners).
5.1.16 Lack of clinical governance and support for nurse prescribing in primary health care

The Pharmacy Council pointed out the lack of clinical governance across primary health in New Zealand.

The Council is concerned the focus in this proposal appears to be on “more accessible, timely and convenient care” and does not believe there is enough detail that describes how the safety of this service is assured. Particularly, collaboration with other health professionals seems to be less of a focus than for a specialist nurse prescriber, potentially fragmenting patient care. Accessible, timely and convenient access should be balanced with safe and quality use of medicines. The model of registered nurses prescribing in diabetes health works well, where nurses in specific areas of practice build up a significant knowledge base and ability to apply this through experiential learning. Council is concerned about the assumption that the same level of safety and quality would occur in a more general practice setting. In that regard, the proposed model for community nurse prescribing in New Zealand cannot be compared with the UK model, as the latter has stronger, more robust clinical governance than the primary care setting in New Zealand (85, Pharmacy Council of New Zealand).

Other submitters also expressed concern about the lack of clinical governance and mechanisms to support nurse prescribing in primary health care.

Clinical Risk
While the regulator will put mechanisms in place to assure the public of practitioner competence, there are currently no defined structures in place nationally that provides a framework for DHBs, PHOs etc. to manage the clinical risks arising from non-medical prescribing i.e. lack of clinical governance structures. This could be a clinical risk for organisations like ours.

Many nurses would be able to cope and add value to health care with prescribing but feel the constraints, training and infrastructure has not been thought through and while this may be beneficial to Primary care it would be very difficult to develop in this context (190, Te Awakairangi Health Network Clinical Governance Committee).

We have concerns about unintended consequences. These include issues with IT not being connected across sectors increasing risk of poor communication and fragmented care. Additionally there are concerns about the funding and release time etc. that will be needed for nurses to undergo the training for either type of prescribing. How will this be supported by Health Workforce NZ? Also the current primary care funding models need to be addressed. These need to change to accommodate this proposal or we will not achieve increased access, choice etc. for clients (96, MidCentral/ Wanganui DHB Regions Primary Health Care Nurse Practitioners and Interns Peer Review Group).
Other submitters were concerned that some of the collaborative features of the specialist nurse prescribing model were absent. Some wanted collaboration with other health professionals included (85, 159, 173) or the requirement for communication with the patient's GP, or access to records (34, 68, 86, 187). Supervision (173) or supervision for six months was suggested by some (83). One submitter commented that these nurses would need to “work across professional and organisational boundaries” (185).

In summary, robust systems able to withstand audit would be required before nurse prescribing could be contemplated by a provider, and in order for nurse prescribing to enhance client care, the emphasis would need to be on partnerships that cut across disciplinary, professional and organisational boundaries (185, Royal New Zealand Plunket Society Incorporated (Plunket)).
5.2 Title for community nurse prescribing (Question 1.3)

The Council used the title ‘community nurse prescribing’ for the proposal but was aware that it may not best describe the nurses who may undertake this type of prescribing or inform the public or other health professionals about the breadth of the prescribing authority. Most submitters (71.6%) did not support the title (see Chart 3).

Chart 3: Community nurse prescribing title

Reasons given by submitters for not supporting the word ‘community’ within the title of this proposal were: it is confusing, it is too broad, it is associated with second-level (enrolled) nurses and community workers, and it is too limiting as this type of prescribing might be appropriate in other settings. Some submitters did not support the proposal so did not support the title (1, 36, 43, 83, 178).

5.2.1 Support for community or primary health in title

Forty-five (21.1%) submitters supported the community nurse prescriber title. Some submitters commented on supporting the title (7, 8, 10, 25, 37, 78, 87, 133).

It captures the key inter-faces of the nurse with the primary community health population and the activity of prescribing (8, Individual Nurse).

Other submitters supported variations such as community primary nurse (74), community nurse with basic prescribing rights (21), registered nurse community prescriber or community RN prescribing (154).

Many submitters suggested a variation on primary (health or care) nurse prescriber (32, 40, 41, 46, 58, 74, 75, 94, 98, 99, 111, 116, 141, 147, 155, 156, 157, 158, 172, 185, 190, 196) and one suggested registered nurse prescriber for primary care (109).
We agree that an all encompassing term to cover District Health Nursing, Public Health Nursing and Primary Health Care Nursing is required. All of these fields of practice are external to the acute hospital setting and manage care in our communities at a level of health provision that facilitates return to health and or health optimisation. We support the term Primary Nurse Prescriber (40, Department of Corrections Health Services).

Our discussion was split between the titles ‘Community Nurse Prescribing’ and ‘Primary Health Nurse Prescribing’. This term is broader and reflects the current language i.e. ‘College of Primary Health Care Nurses’. A term that clearly describes the level of practice and prescribing would be preferred as opposed to one that infers a practice setting. In essence, a nurse working in an ambulatory care centre in a hospital may apply for ‘community nurse prescribing’ however this title suggests the nurse works in ‘the community’. The term ‘community’ needs more thought to ensure it encompasses all work settings (98, NZNO (Diabetes Nurse Specialist Section)).

5.2.2 Did not support community nurse prescribing title

Thirty-nine submitters (22%) commented that they thought the title was too confusing to health professionals and the public (12, 17, 26, 29, 38, 39, 40, 48, 54, 55, 59, 64, 66, 67, 77, 85, 86, 96, 97, 102, 106, 115, 118, 102, 115, 125, 126, 137, 144, 145, 150, 153, 159, 164, 174, 176, 179, 192, 195, 197).

… what is a “community nurse”— if it is not clear to those of us in the profession then how can it be clear to the public and other health professionals and how does it explain the breadth of the prescribing authority (125, Group of Nurse Practitioners).

One reason given for the confusion was that some nurses who might prescribe were based in clinics or general practice so were not technically in the community, i.e. providing care in the home.

Sexual Health Nurses are specialist nurses usually attached to a Health Board and may bridge the gap between primary and secondary healthcare but are not technically in the community. I think this could be confusing. Community nurse and District nurse could be seen as interchangeable (66, Individual Nurse).

Others thought it would be too confusing for nurses based in primary care to have two levels of prescribing (125). Some submitters thought the title was too broad (45, 47, 49, 63, 140). Some thought ‘community’ should be better defined by the Council (54, 79).
No too broad a title, the public will assume every nurse that goes in the community will be prescribing (45, Individual Nurse).

It is too broad a term. It doesn’t tell me in which area is the nurse mainly practicing in (63, Individual Doctor).

Others did not like ‘community nurse’ because it was last used as a title for a second-level nurse similar to enrolled nurses (40, 44, 51, 65, 73, 74, 79, 119, 120, 139, 147, 155, 156, 163, 183) or is a term sometimes used for district nurses (147, 166). Others thought community had too many other meanings (45, 75, 111, 182, 196) or could be confused with community workers (185). Some submitters commented that the title was too limiting (129) and that this prescribing authority was not just for community nurses but could encompass secondary (75, 80, 90, 105, 111, 112, 119, 126, 138, 140, 150, 168), emergency (148), mental health (76), or aged residential care (74, 122, 130, 131, 132, 149, 182, 187).

Consideration should be given to another name. Why not registered generalist nurse prescribing (covers mental health nurses who have generalist mental health nursing roles) and specialist nurse prescribing. We perceive that the focus of the consultation document is that this designated prescriber is aimed at registered nurses working in schools, general practice, public health, Maori and Pacific Health providers, services for youth, family planning. However other specialised area nurses working in nursing roles within community settings such as mental health and addiction should be able to access this “qualification” as the trend towards addressing people’s physical as well as mental health issues falls heavily on mental health and addiction nurses. This is particularly relevant as we see more mental health care moving towards primary care services (76, Te Ao Māramatanga, NZ College of Mental Health Nurses).

5.2.3 Alternative approaches suggested by submitters

Submitters suggested using the registered nurse title with two levels of prescriber or a range of alternative titles.

Many submitters stated they did not think new titles for nurse prescribers would be helpful and preferred the use of the scope title by adding prescriber, i.e. registered nurse prescriber or ‘specialty’ nurse prescriber (17, 26, 39, 41, 60, 72, 104, 116, 119, 120, 122, 139, 153, 172, 183, 191).

Community nurse prescribing is very broad and doesn’t adequately explain the nature of the prescriber nor the ability/education/breadth of the prescribing nurse. There is a need to better define the areas of practice covered by “Community” and “Specialist” prescribing. These terms sit outside the recognised scopes in nursing (Enrolled Nurse, Registered Nurse and Nurse Practitioner) and may create confusion. It is suggested that if two levels of prescribing are required for Registered Nurses that they be defined as Registered Nurse
Level 1 and Registered Nurse Level 2. We suggest the overall title should be Registered Nurse Prescribers which is very inclusive (153, Nurse Maude Association).

Many submitters supported ‘Level one’ and ‘Level two’ prescribers or that the levels be attached to the formularies (27, 34, 36, 42, 50, 57, 59, 73, 75, 80, 92, 111, 122, 123, 124, 130, 131, 132, 138, 149, 150, 151, 158, 162, 175, 182, 183, 187). One submitter suggested that in the future all nurses may be able to ‘prescribe’ over-the-counter medicines (80) so the title decision needed to be future proofed.

RN prescriber - Level 1 Formulary and RN prescriber - Level 2 Formulary (to include level 1 Formulary) (122, District Health Board).

A few suggested registered generalist nurse (35, 76, 168, 179). Other suggested titles were designated nurse prescriber (161), nurse prescribing for common ailments (73, 179, 110) non-specialist nurse (5), elementary (27), supplementary (66, 106), limited or restricted (67), and protocol prescribing nurse (148).

It is feasible that this level of prescribing may be used in areas such as Emergency Department by RNs providing primary care and response or in smaller rural hospital settings or aged care facilities. Community nurse prescribing does not reflect the range of practice settings – suggest that this level of prescribing is called Protocol Prescribing – Nurse; potentially with a subtitle as to which protocol is being used by the individual nurse, e.g. Protocol Prescribing – Ear Nurse, Protocol Prescribing – Aged Residential Care; Protocol Prescribing – Primary Practice, etc. (148, Government Agency).

Two submitters suggested the specialty should be included (118, 163) and one suggested the existing job title should be used (136).

5.2.4 Other comments

Other submitters commented that in selecting the title it was most important that employers and the public understood (122, 130, 131, 132, 149, 182, 187).
5.3 Scope of practice and authorisation for community nurse prescribing (Question 1.4)

The Council proposed 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.”

Most submitters (74.7%) agreed 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 for community nursing prescribing authority.

Agree in principle but would need the title clarified as above first. A prescribing authorisation is the most straightforward way for this ‘level’ of prescribing to incorporate this added authority. Future proofing for subsequent inclusion of new graduate nurses when they qualify with authority to prescribe OTC [over-the-counter] medicines (75, Primary Health Care Leadership across Waitemata and Auckland districts).

We agree that wording be changed to the registered nurse scope of practice with a prescribing authorisation for community prescribing. We do not believe that there needs to be an additional level of nurse introduced or new scope for nurses who qualify to prescribe (94, Wairarapa District Health Board).

Five submitters indicated that it would be more appropriate if nurse prescribers were registered in a different scope (7, 22, 173, 178, 192, 196). One submitter suggested that the responsibility and safety implications of prescribing warranted a new scope of practice (173).

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 (178, Pharmaceutical Society of New Zealand).

A number of submitters suggested changes to the wording. Many commented that the statement was not clear enough about the experience and qualifications and needed to be better defined (63, 67, 74, 90, 109, 115, 150, 181). One suggested adding the required years of experience and another the word ‘highly’ before ‘experience’. Many submitters suggested removing the word “some” (73, 76, 86, 119, 120, 122, 130, 131, 132, 145, 149, 179, 182, 187, 191). One suggested using ‘identified’ nurses (43) and one said use ‘registered’ nurse (84). Others commented that ‘specified’ (5), ‘relevant’ (122, 149) or ‘high
level’ or ‘approved’ (79, 105, 147, 158) be inserted before ‘education’. Some submitters
wanted the words ‘approved formulary’(1), ‘limited range of medicines’ (35, 44, 145), ‘certain
medicines’ (117) or ‘specific medicines’ (43) to replace ‘some medicines’. One suggested
adding the requirement for collaboration with other health professionals (85) and one
suggested removing the word ‘training’(39).

5.3.1 Two submitters suggested different wording.

As we support prescribing at this level to be through the development of a protocol
framework our suggestion would be that this read, “Nurses with relevant experience, who
complete a competency based education and training programme may be authorised by the
Council to prescribe medications under the national protocol framework related to the area of
clinical practice in which they are employed” (148, Government Agency).

The general intent of the suggested wording change is in keeping with the proposal. Plunket
proposes a different form of words, which is more process-focused:
“Nurses who meet the criteria may apply to the Council for a designated authority to
diagnose, prescribe some medications and follow-up within their competence and scope of
practice” (185, Royal New Zealand Plunket Society Incorporated (Plunket)).

14 ‘Specified training’ is the language used in the Medicines Act (1981) for designated prescriber
regulations, Section 105B.
5.4 Qualification and training for community nurse prescribing
(Question 1.5)

The Council proposed that community nurse prescribing courses should include up to six
days of theory (online and workshop) and three 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.

A minority of submitters (38.7%) agreed with the proposed education and training for
community nurse prescribing. There was stronger support from submitters for the proposed
programme standards (47.5%) and competencies (60.2%) (see Chart 4).

Chart 4: Support for education, standards and competencies

Some submitters supported the qualification or suggested tailoring the education to specific
medicines nurses would prescribe in some areas of practice. The reasons given for not
supporting the qualification and training were that they were insufficient and the list of
medicines was too extensive. Some thought the education should be at a postgraduate
level. A small number of submitters did not support the qualification as they did not support
this proposal.
5.4.1 Support for the proposed qualification

One submitter suggested this level of education was appropriate for non-prescription medicines and that this should form the beginning of a staircase of qualifications including a postgraduate certificate and a postgraduate diploma in prescribing (153). One saw a natural progression for practice nurses starting with independent vaccinator training (141). Another acknowledged the constraints of postgraduate education in primary/community care (158) and acknowledged that graduate midwives can prescribe.

One submitter thought the proposal was enabling and that nurses were used to working under standing orders anyway (158). A couple of submitters pointed out that new nurses are being educated with more pharmacology in their degree so there may be different education needs for different parts of the workforce (38, 137, 150, 158). Level 7 education was seen as appropriate depending on the medicines prescribed (124).

Varied response received. Majority stated yes when aligned with RN scope of practice requirements.
Some commented that education programme should be set at level 8 for acceptance from medical colleagues. However there was comment that this may be limiting as there are many constraints for PG study in the primary/ community healthcare setting.
One comment from undergraduate education provider that we need an enabling process and any conservative barriers for prescribing in community settings need to be thought through carefully. New graduate midwives prescribe therefore we need to think really carefully about being too PG focused for nursing.
Comment that RNs are used to working under standing orders so would be straightforward for them to transition.
Comment that nurse with a lot of clinical experience may not have studied pharmacology.
Discussion held between Primary and Rural sector on needing a transitional process until undergrad is aligned, e.g. two streams of education, one for those trained years ago, versus those recently trained – possibly create a modular form of training so that one builds on the other. However the Director of Nursing group in the main supported the training as per consultation document.
One comment from Mental Health and Addiction education provider seeking clarity from Nursing Council on how accreditation process will occur to ensure public safety (158, Canterbury Regional Directors of Nursing and Canterbury Postgraduate Nursing Education).

5.4.2 Qualification and training insufficient

Many submitters thought the training was too short. Many simply commented that it was insufficient but did not indicate how long it should be (3, 13, 22, 28, 37, 38, 39, 41, 52, 63, 67, 68, 69, 74, 83, 85, 86, 88, 96, 97, 98, 102, 108, 109, 116, 117, 121, 125, 135, 137, 140, 143, 144, 159, 161, 171, 173, 174, 178, 179, 181).
Suggest that the minimum time required to complete theoretical training should be increased. We hold concern that the majority of training will be done online with only one face-to-face workshop. We recommend that the period for training be extended to 3-6 months. We are supportive for Level 8 papers. The proposed broad range of medications under the community nurse prescriber’s scope does not necessarily reflect the proposed scope for treating minor ailments/infections and the course standards need to support this (116, Non-Government Organisation).

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 (178, Pharmaceutical Society of New Zealand).

My biggest concern (having taught bioscience & pharmacology extensively at undergraduate and post graduate level) is that the undergraduate nursing degree education is often insufficient to prepare post graduate nurses for pharmacology and prescribing papers. In the US and UK undergraduate nursing courses contain biochemistry etc. I think Nursing Council really needs to address this to ensure future nurse prescribing is set up for success (6, Individual Doctor).

A few submitters commented that there was potential for misdiagnosis based on the length of education (100, 108, 125).

The proposed level of training and education does not seem adequate nor rigorous enough for the suggested list of medications that would be available for the nurse to prescribe. Nurses will be assessing and diagnosing without pathophysiology, advanced clinical assessment and diagnostic reasoning education and without successfully completing a prescribing praxis.

There is a risk of inaccurate diagnoses and treatment of conditions thereby exacerbating the initial problem and leading to extended length of treatment remediation (125, Group of Nurse Practitioners).

Others thought the supervision was too light (143, 149, 181, 182, 187), the training needed to be over a longer period of time (98, 143, 168) or more face-to-face workshops should be included (166).
Education of and supervision for nurse prescribers is a critical issue. Prescribing is complex and to safely prescribe the drugs listed in the consultation document, some of which are complex in their effects and side-effects, formal education needs to be comprehensive and supported by a significant amount of supervised clinical experience—much like a medical degree. A ‘safe’ amount of knowledge cannot be acquired over a short period of time. The proposed training for community nurse prescribers of six theory days and three days of supervised practice is certainly not sufficient. While the proposed postgraduate diploma for specialist nurse prescribing does cover more content, it is unlikely to cover the complexities of prescribing within a specialist mental health setting. Supervision of prescribing should be ongoing rather than just for six months, and include mentoring and monitoring by experienced prescribers. This will have an impact on services (143, The Royal Australian & New Zealand College of Psychiatrists).

The six day course needs to be clarified more, e.g. how many hours is this, and how much time is dedicated to the various components e.g. legal. There is concern that the majority of training is described as online with one minimal face-to-face workshop. Nurses working in primary health have a range of experience and background and many may learn better with more chance for face-to-face discussion to help develop confidence and competence. One face-to-face workshop is considered inadequate. Clarity is required around the suggestion that the course may be up to 6 days. Does this time frame include the assessment requirement? Length of course may be adequate for more experienced nurses. We recommend that the course standards are national. It is suggested that the mentoring provided particularly for outreach nurses and Public Health Nurses is measured more by numbers of patients/clients rather than days. Practice nurses suggested that 3 days mentoring is adequate as they generally have more support from clinicians on site (166, Group of Nurses, Primary Health).

Some submitters compared the proposed qualification with the independent vaccinator programme (37) and the ECP course (107, 109), and thought it needed to be more rigorous.

I don’t believe 6 days of theory will be sufficient to meet the standards and competencies. In comparison to the Immunisation Advisory Centre preparation of Authorised Independent Vaccinators the proposal is almost trivial. IMAC requires theory with examination (2 day course) and practicum assessment, to administer scheduled immunisations (in effect standing orders) for a limited range (vaccines) and specific list of items. They also require practising certificate, CPR and indemnity insurance evidence (37, Individual Nurse).

Some thought the education and training requirements should be the same as in the United Kingdom (85, 100, 173).
This proposal for community nurse prescribers in New Zealand is considerably more ambitious than the UK model but the course requirements appear to be considerably less. For example, the University of Northampton offers both level 6 and 7 modules which require 6 months part-time (26 university days) and 12 days supervised practice (work-based learning). The PG Cert non-medical prescribing course at London South Bank University also runs over six months part-time, while the University of York programme, which aims to prepare community nurses without a specialist practitioner qualification to prescribe, is a 20 credit Level 6 course. Council strongly recommends a course at least as comprehensive and of similar duration as the UK Community Practitioner Nurse Prescribers as the minimum requirement if nurses are to prescribe from the indicative medicine lists in the proposal. It is relevant to note that the UK qualifications do not lead to an authority to prescribe medicines classified as prescription only (85, Pharmacy Council of New Zealand).

One submitter wanted joint education from medicine and nursing outside of the universities (196).

Many submitters were concerned at the range of medicines in the list and suggested a higher qualification was needed (27, 39, 116, 124, 130, 131, 132, 164, 180) or that the list be narrowed (124).

For nurses to prescribe from the full community formulary this level of education appears insufficient. However many nurses will only prescribe from a narrow set within the formulary of low risk and OTC medications. Education needs to be tailored to the type of prescribing practice the nurse will undertake.

NZHHA suggests that the Nursing Council have further discussions with senior community nurses to provide advice on the right level of education and training, entry to community nurse prescribing and continuing competence. NZHHA happy to assist this process. Providers are supportive of a mix of online training and learning sets, and that Level 7 would be the appropriate level for training. Providers also comment that the ability for nurses to prescribe would also require an increase in the use of medication decision support tools. They also had questions about how oversight of medication prescription would be monitored (124, New Zealand Home Health Association Inc.).
5.4.3 Postgraduate education needed

Other submitters were of the opinion that some postgraduate education was needed. This ranged from those who suggested one paper (17, 20, 129, 155, 156) to two papers (21, 57, 79, 127) or a postgraduate certificate (7, 34, 36, 40, 41, 46, 48, 50, 51, 59, 48, 75, 94, 104, 111, 118, 123, 148, 153, 167).

Whilst the standards and competencies for this level of prescribing are robust, the group have significant concerns at the lack of a formal postgraduate pathway in preparation for prescribing. The level of theoretical and experiential learning required to safely, competently and confidentially prescribe requires significant mentoring and support. Our suggestion is that this takes the format of a Postgraduate Certificate level programme, focusing on theoretical knowledge attainment and the development and demonstration of competency over more than a 3 day supervised practicum. With the ongoing improvement in technology there is no reason that this level of education could not be delivered as a distance programme (taught online). Our preference would be that this education is linked to tertiary providers who currently already prepare potential nurse practitioners for prescribing. Nurse prescribers should be expected to maintain a professional portfolio which provides evidence of their competency to prescribe within their scope (whether it be protocol based prescribing or specialist nurse prescribing) (148, Government Agency).

Others suggested three postgraduate papers (95, 125, 147) and some did not state how many (63, 118, 164, 175, 195). Nine submitters commented that it should be the same qualification as for specialist nurse prescribing – a postgraduate diploma in prescribing (20, 21, 26, 29, 77, 90, 91, 119, 120, 160, 192).

The addition of Nurse Prescribing to the Expert Nurse is an earned and well deserved advancement to the current role. However, three separate levels of Nurse Prescribing would be confusing to the public and to other health professionals, resulting in the requirement of having to consult numerous documents to ascertain at which level the Nurse Prescriber is at. The amount of education required should also not differ as it could be perceived as ‘dumbing-down’ the responsibility of nurses at the community level. It is essential to have the appropriate amount of education, which we believe is a Post Graduate Diploma as a minimum requirement for both the Community Nurse Prescriber and the Specialist Nurse Prescriber, which in essence makes the division of two separate roles a mute point. The amount of education should not be seen to disadvantage the nurse wanting to move up to this role as they would most likely be well on their way to achieving this already. In other words, nurses whom are excellent candidates for these roles would already be gravitating towards increased learning and formal education. The requirement of a Masters education with prescribing for the Nurse Practitioner would continue to be essential. We therefore propose two levels of Nurse Prescribing, that of the Specialist Nurse Prescriber, which would include both of the community and specialist proposals, and that of the Nurse Practitioner Prescriber (192, Neonatal Nurses College of Aotearoa - NZNO).
Several submitters suggested that recognising existing prescribing qualifications from NZ (and overseas) (66, 106) would enable many nurses to be authorised for this type of prescribing (19, 66, 82, 99, 106, 126).

We agree with the above statements however would like to see recognition of prior learning with those that have completed a Diploma in Health Sciences which include level 8 papers of advanced health assessment, research, pharmacology and specialty papers. We would also like to have UK, Irish and Australian nurses’ prescribing qualifications recognised in NZ (as this is what the standards are based on) and they have actually achieved the proposed standards. Instead of them having to re-sit the standards (106, New Zealand Sexual Health Society (NZSHS)).

Three submitters thought the qualification should be similar to that of the pharmacist prescriber or the diabetes nurse prescriber (60, 98, 107). One commented that the programme should be "many years" (23) and another that it should be the same as for doctors (62).

Both the six days theory and three days supervision is too light and inadequate. Experience gained from the Diabetes Nurse Prescribing project is that nurses gain knowledge and confidence with prescribing over time with on-going learning, support and case review. Members felt that the community nurse prescriber competencies should be equivalent to the specialist nurse prescriber competencies which would be the minimum requirement for any nurse to prescribe. All nurses would need to demonstrate depth and breadth of knowledge within their speciality when assessed against the competencies. In addition it needs to be a requirement that the nurse demonstrate when to consult and refer. Concern was raised that the proposed minimal training programme is not in line with other nurse prescribers or pharmacist prescribers. Again concern has been expressed that the proposed training programme is inappropriate for the list of medicines in the proposed list (98, NZNO (Diabetes Nurse Specialist Section)).

The proposed ‘education/training’ is grossly and dangerously inadequate for safe prescribing. It also fails to take into account the fact that correct assessment and diagnosis informs all types of medical treatment via prescribing. The current proposal would generate negligently incompetent nurse prescribers. To be able to safely prescribe nurses must undertake relevant education equivalent to that of doctors. Currently medical Trainee Interns are not recognised as safe to prescribe, therefore anything less than a level of education equivalent to that of a first year house officer should be considered inadequate. Additionally Nurses should have to undertake extra training in clinical assessment and diagnostics, as significant medication harm often occurs as a result of errors of diagnostic assessment (62, Individual Doctor).
5.4.4 Focus the education on specific areas of practice, use existing courses and protocols

A few submitters suggested narrowing the range of medicines (136) and linking them to guidelines or decision support tools (122, 124, 150) stating that there are already a range of short courses that nurses can undertake to dispense medicines under standing orders which could become national online courses.

… Whatever the outcome to the consultation process a national standard and framework must be applied. Consistency is important. If on line learning is an enabler then this should be available on the Ministry of Health website and free to all RNs. Support a range of short courses for specific areas of practice and specific groups of medicines within Formulary 1, rather than ‘6 days’ for all. Supervision element needs to be included and standardised. Recommend RN on expert level of PDRP for prescribing. Short courses, defined by an area of practice and a set of established guidelines/protocols, with designated access to specified medicines within Level 1 Formulary. For example targeted education for the assessment, management and treatment of skin infections would support nurses to prescribe specific (or a limited range of) medicines within Level 1 Formulary; Assessment, treatment and management of Sore Throats (as per the NHF Guidelines); same for Sexual Health Services; Family Planning; Aged and Residential Care (122, District Health Board).

Consideration needs also to be given to diagnosis training for common conditions and use of clinical guidelines/decision support tools. There needs to be the ability to link this training (if a short course) as a pathway to post grad and nurse practitioner training. We do need to be cognisant of the pharmacology education that RNs are now graduating with and ensure what we describe allows a transition for our more experienced RN workforce to support validation of knowledge and skills through a rigorous means. Consideration needs to be given to e-learning, and how competency is shown with e-learning (150, Compass Health).

This is assuming that the 6 day training is specific to individual areas of practice? E.g. Family Planning or skin conditions (136, Group of Nurses, Public Health).

Family Planning also argued for a specific credentialing process based on the training programme it already has in place for standing orders, which sits outside of postgraduate education (72).
We strongly believe that there is a need for a stand-alone process for credentialing nurse prescribers in specialised settings such as Family Planning clinic. For us, and no doubt some other providers, the ideal situation would be for the Nursing Council to recognise, in addition to pre-determined generic pathways, customised processes for developing nurses as prescribers. We currently have a very effective model for preparing nurses to supply medication. The process offers an extensive practicum period of support and checking, and identifies which nurses meet the standard to progress to audit rather than countersigning. An additional module similar to that proposed in the consultation document, would bring our nurses to the level of RN prescriber in our area of sexual and reproductive health. An additional theory module could be developed to include

- Underpinning legislation, schedules of medicines, access to subsidies, ethical obligations
- Pharmacology related to prescribing for our area of practice
- Safety of drugs
- Antimicrobial resistance and prescriber responsibilities

We feel that the proposed course, in the consultation document, may be too generic for Family Planning nurses as our area of practice is not focused on chronic disease management. However if and when courses are offered by tertiary providers, Family Planning would look at the feasibility of incorporating such a course into our training for nurses (72, Family Planning).

5.4.5 Other comments

Two submitters were concerned about where the course would sit on the NZQA education framework and whether HWNZ would fund it (44, 156).
5.5 Standards and competencies for community nurse prescribing (Questions 1.6 and 1.7)

Many submitters agreed with the competencies and the programme standards for community nurse prescribers.

The standards and competencies are comprehensive and achievable and will ensure safe practice (35, Group of Nurses).

Standards look comprehensive but doable for education providers. Competencies seem appropriate and sensible (157, Individual Nurse).

Generally speaking, the standards for community nurse prescriber courses in Appendix 3 appear comprehensive and robust and incorporate a key skills and knowledge framework in preparation for the role (185 Royal New Zealand Plunket Society Incorporated (Plunket)).

Others supported the competencies and standards but wanted more emphasis on patient or consumer focus, and informed consent (14, 39, 78, 185).

We think the course standards and competencies require improvement to be made more consumer focused. In particular, “Educating the patient” is mentioned but the course standards but does not go far enough as there are no specific details about an informed consent process in regards to ensuring who is prescribing and what is being prescribed. Nor does this ensure that consumers are engaged in understanding the treatment prescribed and that it is being prescribed by a nurse. This also needs to be detailed in the competencies section (14, Women’s Health Action).

The content covers safety and ethical practices. We would be keen to ensure that it also includes patient relationships/knowledge and/or skills to encourage patients to say if the treatment is not working/not working well enough (feedback) (78, Matua Raki- National Addiction Workforce Development).

The six standards for the prescribers’ course at page 50 are comprehensive and robust. It would further enhance the standards to see a greater emphasis on partnership with patients/clients and the development of collegial relationships with other healthcare professionals involved with these clients. The key areas of diagnosis and follow-up need to be given greater emphasis. There is also little mention of the role of informed consent when prescribing; this is particularly important child and youth health as it can be complex in that area. [In the] competencies for community nurse prescribers- Again it would be helpful to articulate an ability to work with patient/clients as partners in treatment (185, Royal New Zealand Plunket Society Incorporated (Plunket)).
Some submitters suggested adding competency 2.2.9 and/or 2.1 from the specialist nurse prescribing competencies to the competencies for this level (57, 130, 131, 132, 149, 182, 187).

… Suggest that “Knowing when to refer on” and how - 2.2.9 from specialist nurse prescribing is also added to the requirements (57, District Health Board).

Seven submitters commented that both proposed prescribers should meet the competencies proposed for specialist nurse prescribing (40, 54, 85, 98, 168, 173, 179).
5.6 Entry criteria for courses leading to community nurse prescribing (Question 1.8)

The Council proposed 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 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.

Most submitters (62.2%) supported the entry criteria for community nurse prescribing courses. Several submitters commented on their appropriateness (4, 14, 39, 40, 75, 78, 80, 126, 136, 139, 163).

The criteria have been well constructed to ensure individual, employer and training aspects are draw together and that appropriate systems and process are in place that support this level of prescribing. Having to show you have support from your employer and have an authorised prescriber mentor will ensure this ‘training’ is restricted to the nurses who will upon successful completion add this to their practice (80, District Health Board).

We support the provision of additional training and the requirement that the nurse has been in practice for at least 3 years (14, Women’s Health Action).

Years of experience attracted many comments. Forty-nine submitters commented that this requirement was inadequate. For example many submitters indicated that one year in a specialty area was not enough to gain the experience needed to diagnose and prescribe in community settings (21, 23, 27, 41, 44, 51, 63, 102, 116, 139, 140, 158, 159, 163, 167, 185, 190, 196).

From experience nurses are more likely to develop proficient level of practice when they have been working in an area for a minimum of 3 years. Working in an area for only one year before becoming a nurse prescriber may not provide a nurse with the repeated experiences to recognise and be able to diagnose conditions correctly and then safely prescribe medication. With 1 year of experience their ability to diagnose may be very narrow in comparison to a nurse who has more knowledge and experience in area of practice (51, Individual Nurse).
The first statement of the entry criteria needs more consideration; one year in a specialist area (such as child health) is too short a time span to be safely and competently diagnosing, prescribing and appropriately following up (unless prior experience is recognised). (Standards of proficiency for nurse and midwife prescribers, London: Nursing and Midwifery Council)...The Consultation document refers to the United Kingdom experience of nurse prescribers. It is helpful to bear in mind some differences between the two countries; for instance, in the UK the community nurses (Health Visitors and District Nurses) prescribe from a formulary. In the UK, Health Visitors and District Nurses already hold a Specialised Practitioner Qualification, and hence the prescribing education programme for this group is built upon this premise. It would be risky in Plunket’s submission to extrapolate from the UK experience to the NZ context, where specialist nursing practitioner qualifications are fewer (185, Royal New Zealand Plunket Society Incorporated (Plunket)).

One submitter suggested 18 months’ experience (34), ten supported two years (1, 35, 38, 66, 67, 81, 106, 175, 179, 187), two supported two to three years (98, 129), and fourteen supported three years’ or more experience in the area the nurse would prescribe before commencing the programme (20, 31, 46, 60, 95, 96, 105, 125, 138, 147, 164, 166, 185, 195). Eight others suggested the nurse should have five years’ or more experience (13, 54, 86, 91, 110, 123, 166, 171).

Three years full time practice is insufficient to develop the skills, knowledge and confidence to prescribe. We feel that five years full time practice with at least one year in the area of practice she/he will be prescribing in is more appropriate (13, Group of Nurses, DHB CNS).

Yes, however, Public Health Nurses and outreach nurses state 5 years equivalent full time practice is required before prescribing. Practice nurses consider 3 years is adequate as they are supported well by GPs on site. Nurses, who move from one area of specialty to another however, may require more than one year to become proficient in the new area of practice and this needs to be considered. Likewise, an experienced nurse may move from an area of work to another (e.g. change employment and practice setting) but in essence continue to work in their specialty and needs to be considered too (166, Group of Nurses, Primary Health).

One submitter suggested nurses should have a period of working under standing orders (47). Several suggested the actual hours should be specified rather than years because some nurses work part-time (33, 122, 130, 131, 132, 149, 182).

Eleven submitters proposed that it was the level of expertise the nurse demonstrated rather than years worked that should be taken into account through criteria including PDRP level (41, 43, 50, 59, 74, 105, 109, 116, 158, 164, 190).

We believe the criteria for entry to be evidenced by nurses undertaking PDRPs within their area of practice e.g. at proficient level (41, Primary Health Organisation).
Others mentioned the different preparation of the nurse workforce, i.e. hospital certificates versus Bachelor of Nursing, and thought the criteria should acknowledge this with some suggesting a nurse should have a bachelor’s degree (48), or be able to study at degree level (85) or at tertiary level (118, 148).

A number of submitters were concerned about the definition of a mentor with some wanting it more broadly defined (87) or credentialled (74). One DHB stated that nurse practitioners in their area did not want to be mentors (57). Others thought the mentors role description was not clear (100, 128, 181).

*It is not particularly clear what the prescriber’s mentor would be required to provide in the way of support and objective clinical oversight (181, PHARMAC).*

Others were concerned about the costs of mentorship, particularly for nurses who did not work directly with a multidisciplinary team (MDT) (59, 111, 124, 165), and costs of audit and education for nurses (41). Two submitters mentioned that nurses are now buying into some general practices so employer-approval criteria are not appropriate in these circumstances (41, 116).

*Providers commented that it would be useful for the Nursing Council to have further discussion with community nurses about entry criteria. Home care providers would need to gain agreements from other health provider organisations to gain the support of mentors who are already authorised prescribers. There will be cost factors that apply which may prove a barrier unless funders appreciate the gains in earlier access to treatment and preventative care (124, New Zealand Home Health Association Inc.).

*We note the requirement for nurses to be employees ... we are increasingly seeing nurses in the employer role. It may be more appropriate to ensure the nurse is affiliated with a network providing the supports outlined. We also believe it should be mandatory for nurses to work under supervision, with robust audit and review processes in place. How are the mentoring/audit/education functions to be funded (41, Primary Health Organisation)?*

Particular concerns were expressed for rural nurses (78, 99) and nurses in schools (155, 156, 178).

*...With the current employment model of nurses in school based health clinics across the Auckland region being employed by the school that this will be a barrier for them to meet this criteria (155, Auckland School Nurses Group).*
We believe there may be some problems with nurses having difficulty getting a supporting employer and an authorised prescriber-- could this not be “should ideally” rather than “must”-- exemptions might need to be vetted by those running the course and if Nursing Council subsequently considers the support inadequate they might decline registration. Circumstances which come to mind are a community health trust which might not be in a position to pay the nurses’ fees to attend the course but might grant her leave without pay to attend. The process should be a bit elastic to facilitate the development of prescribing expertise. The support of a pharmacist might be useful with lesser authorised prescriber input (99, New Zealand Institute of Rural Health).

Several submitters also wanted this level of prescribing to be linked to an MDT (68, 86, 98, 129, 162, 179), and one wanted all members of a team to support the prescribing role (173).

It is not stated that the community nurse prescriber would need to be working in a collaborative/multidisciplinary team. The collaborative view of members was that this needs to be a requirement (98, NZNO (Diabetes Nurse Specialist Section)).

Three submitters wanted more clarity about the employer policy, audit and peer review requirements (51, 59, 111).

What would be some of the criteria that employers would be looking for in order to support appropriate nurses to expand their scope? Some nurses in primary care e.g. Iwi Providers, may not be managed by nurses with current APC and managers may not understand the ongoing requirements for support and monitoring of nurses who prescribe (51, Individual Nurse).

All criteria imperative. Nursing Council criteria on Peer Review need to be explicit to ensure patient safety (40, Department of Corrections Health Services).

A number of others did not support the entry criteria because they did not support the level or length of education proposed (22, 36, 37, 52, 77, 97, 103, 119, 137, 150, 161, 194).
5.7 Continuing competence and monitoring for community nurse prescribing (Question 1.9)

The Council 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 would also have to demonstrate that they have completed 60 days of prescribing practice within the past three years. The Council proposed that it monitors these requirements are met every three years at practising certificate renewal.

Most submitters (71%) agreed with the ongoing continuing competence requirements for community nurse prescribers.

Absolutely. There needs to be auditing systems linked to peer review to show best practice/clinical guidelines and that competency is maintained. Current process for ECP endorsement requires proof of competency and refresher training etc., as does the Authorised vaccinator process (150, Compass Health).

The Directors of Nursing group supported these requirements. RN needs to have on-going endorsement by employer (158, Canterbury Regional Directors of Nursing and Canterbury Postgraduate Nursing Education).

5.7.1 Practice hours

Those who commented on why they did not support the community nurse prescriber continuing competence requirements were concerned that the minimum 60 days of prescribing practice was too short (13, 20, 32, 41, 60, 85, 107, 115, 116, 151, 162, 172, 174, 176, 190, 195) or too difficult to monitor (103, 180). Many suggested 60 days per year.

60 days over 3 years not considered adequate to maintain competency and currency. 60 days annually supported. Due to the nature of the individual roles there will be a variance in the amount of prescribing activity on a day to day basis. Accordingly the number of days of prescribing practice is not an equitable measure. How is this to be evidenced and how can this be measured e.g. by the number of prescriptions issued (41, Primary Health Organisation)?

The Pharmacy Council agrees that nurses who have community nurse prescribing rights must participate in peer review of their prescribing practice and complete professional development on prescribing each year. However, the Council does not support an average of 20 days of practice annually as being adequate to maintain competence in the high risk area of prescribing. Although this follows the Nursing Council general requirements (i.e. practise nurses are required to be practising a minimum of 450 hours every three years and to demonstrate that they are continuing to learn by undertaking a minimum of 60 hours of
professional development every three years) experience suggests 20 hours per year is not sufficient to maintain competence. Twenty hours is less likely to be adequate where the community nurse prescriber is not working in a collaborative environment, or where the practitioner is unaware of his/her lack of pharmacological and pharmaceutical knowledge. Prescribing is a privilege, and although earned, it should not simply be for the nurse to determine his/her competence to prescribe a particular medicine as suggested in the proposal (85, Pharmacy Council of New Zealand).

Alternatively, others thought it was too restrictive (17, 74, 105, 110, 123, 136, 180).

60 days per three years of prescribing practice is constricting and may encourage nurses to prescribe when no prescription is necessary. Opportunity to prescribe on 60 days over three years would be an improvement. How will this be evidenced (74, Group of Nurses)?

If the community nurse prescribing role is developed, access to professional support and development is going to be difficult for isolated rural nurses. Special considerations will need to be developed for rural nurses in this situation. The requirement for 20 days of prescribing practice per annum needs further definition and justification. Auditing and reviewing such a prescribed level of behaviour would seem administratively impractical (180, New Zealand Rural General Practice Network).

Other submitters were concerned about how it could be evidenced (10, 23, 34, 60, 66, 116, 122).

60 days of prescribing practice? There may be real challenges in demonstrating this with integrity does seem rather arbitrary. Needs to be some kind of quality – perhaps this should not be days of practice but rather a combined focus on audit of practice and peer review. All prescribers are linked to pharmacy; prescriber number can also be audited like any other prescriber (122, District Health Board).

Still other submitters wanted it more clearly defined (37, 43, 53, 92, 156, 164) or to include a number of scripts or patient assessments (42, 59, 71, 75, 99, 111, 129, 157, 159).

5.7.2 Professional development

Several submitters supported the annual update with some concerned about who would provide it (51, 75, 95, 99, 111, 175), and one suggested it should be online for rural nurses (99). Two submitters supported two yearly like the vaccinator update (58, 141). Another suggested it should be more than annually (174). A few submitters wanted this better defined (7, 34, 110, 140, 153).
The level and extent of educational development requires further explanation, along with the demonstration of prescribing professional practice e.g. how does the capture of competence occur - could be 60 panadol over 60 days. To ensure continuing competence is met, we recommend registered nurses undertake regular case review of prescribing practice with a suitable mentor as described in box 1.7. It is the nurse’s responsibility to ensure they maintain on-going competency. If nurses do not meet competencies clear processes need to be identified to address this. The nurse could present case studies to demonstrate on-going competence. Need an audit process clearly defined (153, Nurse Maude Association).

5.7.3 Peer review

Peer review was well accepted but some submitters commented that it needs to be better defined, might be difficult to achieve or needs to be supported (36, 39, 47, 59, 75, 82, 118, 151, 153).

…”We feel there is a variable interpretation of peer review. Would recommend a definition of peer review included (75, Primary Health Care Leadership across Waitemata and Auckland districts).

Some thought this should be replaced with a requirement for case review with an authorised prescriber or medical mentor/colleague (39, 48, 99, 173, 185).

Where nurses are undergoing peer review it is appropriate that the doctor who the patient is registered with be considered as a peer and be part of the review. This will ensure more integration of service, consolidate relationships between the disciplines and improve the patient journey (99, New Zealand Institute of Rural Health).

5.7.4 Audit

Some submitters thought an audit of prescribing would be a better approach (57, 59, 111, 122, 130, 131, 132, 133, 149, 182, 187) or the same requirement as pharmacist prescribers (59, 111).

Suggest as an option a prescribing audit every 3 years Alignment with other prescribers ongoing competence e.g. pharmacists propose an audit, peer review and a learning portfolio (75, Primary Health Care Leadership across Waitemata and Auckland districts).
5.7.5 Professional development and recognition programme

Seven submitters suggested requirements be linked to a professional development and recognition programme (38, 50, 59, 96, 98, 123, 179) and others suggested a portfolio (148) or to incorporate requirements into existing professional mechanisms (129). One submitter commented that it should be separate from a professional development and recognition programme (147).

5.7.6 Frequency of monitoring

Some submitters commented on frequency of monitoring suggesting it should be annual (57, 63, 147) or six monthly to start with and then decrease (102).

Two submitters suggested endorsement by the employer and the requirement for an annual declaration and random audit by the Council be made explicit (139, 163).
5.8 Prescription medicines list for community nurse prescribing (Question 1.10)

Chart 5: Support for the community nurse prescribing medicines list

The medicines lists for community nurses were developed from the New Zealand Formulary and Pharmaceutical Schedule for medicines to treat identified therapeutic areas.

Submitters were equally divided in their response to the proposed list of prescription medicines with approximately half (49.6%) agreeing and half (49.6%) disagreeing with the proposed list for community nurse prescribers (see Chart 5 above).

5.8.1 Support for the prescription medicines list

Some submitters made comments that supported the breadth of the list (49, 61, 66). Two submitters thought many of these items are already administered under standing orders and saw this option as being safer for the public because of the variable education of nurses using standing orders (56, 121).

The list will enable clinical decision making and critical thinking for on-going care in community settings for the well population regarding contraceptives, vaccines and other medicines. The list may not be as encompassing as the public would expect - they may see chronic care support especially if well and stable sitting within this list (49, Kimi Hauora Wairau Marlborough Primary Health Organisation).

The community nurses list contains all the relevant medications required for a Sexual Health Nurse to run Nurse Led Clinics effectively and timely for the patient (66, Individual Nurse).
The College also notes that many of the medicines on the proposed list are currently supplied and administered to clients under standing orders. Education and competence assessment processes for standing order use by registered nurses are currently highly variable. We therefore consider that it would be safer for registered nurses to prescribe these medicines independently because of the standardised authorisation (education and competence) requirements (56, College of Nurses Aotearoa New Zealand).

5.8.2 List is too extensive

Many submitters commented on the list of prescription medicines being too extensive (13, 22, 23, 27, 31, 36, 38, 39, 41, 51, 56, 57, 59, 63, 68, 97, 98, 99, 100, 107, 115, 116, 125, 127, 137, 147, 148, 150, 153, 158, 164, 168, 170, 173, 174, 176, 178, 179, 180, 186, 196, 194) or that it should be restricted (54, 81, 105).

This is a VERY extensive list for community RNs to prescribe from re proposed area uncomplicated minor ailments/infections and illness. There are many medications that could potentially cause risk to the patient should an RN not have full access to knowledge of the patient’s other conditions and understanding of long term condition medications re potential to interact. I would recommend further consultation with Pharmacists/consultants re the extensive list. I believe the list could be modified to the most commonly = best practice prescribed medications. There may be some medications required in community, in this instance the RN may be required to consult with the GP/NP recommendations for some drugs they wish to prescribe (38, Individual Nurse).

The College considers that the indicative community nurse prescribing and specialist nurse prescribing lists are too extensive. They contain the vast majority of medicines that GPs could prescribe. They also contain many dangerous medications that even GPs would think very carefully about prescribing, or would prescribe only on specialist recommendation (194, The Royal New Zealand College of General Practitioners).

5.8.3 List not confined to minor ailments

Other submitters did not think the list reflected the proposal for minor ailments and infections, and that it should be modified to reflect this. One commented that psoriasis should not be considered a minor ailment (86). One suggested the Council needs to more clearly define the “healthy” person the nurse would be prescribing for (100). Another submitter commented that some of the medicines should be on the specialist nurse list (85).

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 (178, Pharmaceutical Society of New Zealand).

This list goes far beyond what is required to provide medication for minor ailments, common infections, contraception and disease prevention. There are so many medications that could potentially cause risk to the patient should the nurse not have full knowledge about all the patients other conditions and also other long term medications where there is a potential to interact (96, MidCentral/Wanganui DHB Regions Primary Health Care Nurse Practitioners and Interns Peer Review Group).

5.8.4 Too many medicines for length of course

Twelve submitters thought there were too many medicines on the list in terms of length of the course (50, 52, 65, 77, 100, 110, 123, 144, 150, 164, 165, 192). One submitter thought nurses should complete education similar to the UK model (100) and two submitters thought all nurses should undertake the same education, i.e. that proposed for specialist nurse prescribers. (119, 120).

The extensive list of prescription medicines does not equate to the education components of the course and the length of the course (144, Group of Nurses, Community Health).

If this consultation document is accepted, we feel that the amount of education currently being considered is inappropriate to allow for prescribing of medications such as antibiotics, antifungals, antibacterials, antivirals, corticosteroids, antineoplastics, etc. Multi drug use is common in the community and interactions and adverse reactions are always potential risks when prescribing. The level of education currently on offer for this scope is insufficient and unsafe (192, Neonatal Nurse's College of Aotearoa- NZNO).
5.8.5 PHARMAC-restricted medicines

Some submitters noted that some medicines on the list were “specialist only”\[^{15}\] (60, 63, 83, 86, 98, 127, 128, 177), “retail pharmacy specialist” (86) or “special authority”\[^{16}\] (60, 83, 86, 181, 185). Some submitters thought these medicines should not be on the list. One submitter identified an example of where a nurse may prescribe a special authority item.

| Note that [the Council] has said that medicines (and devices) that are not subsidised or require special authority have mainly been excluded from the lists. However, there are still quite a number of these proposed—will the [Council] expect that Pharmac will approve community nurses to apply for SA? Several of the medicines are listed in the Pharmaceutical Schedule as “Retail pharmacy specialist”. This means that in order to obtain a subsidy, GPs must consult a specialist for approval. This is a good indicator that a medicine has special prescribing considerations and would not be considered a common medicine for a minor ailment and therefore these medicines should be excluded from the list (86, CAPA - Clinical Advisory Pharmacists Association). We have some particular concerns with some of the listed items:

| • Methotrexate and Tretinoin are only subsidised on the recommendation of a specialist.
| • Valaciclovir is only subsidised via a Special Authority. Applications are only accepted from a medical practitioner (doctor).\[^{17}\]
| • Many antibiotics (clindamycin, itraconazole, ketoconazole etc.) now have strict rules and guidelines on who can initiate treatment. Even GPs may not initiate these treatments without recommendations from a DHB hospital specialist.
| • Cyproterone is listed as a hormonal contraceptive. However, by itself it is an androgen antagonist and may only be initiated by a specialist.

These products stand out to us on a first glance\[^{18}\] of the full list—however there may be other listed products with similar restrictions.

We are also of the view that consideration should be given to restricting by indication, as well as by pharmaceutical. We would note that diabetes nurse prescribers cannot initiate a Special Authority application, or initial prescriptions (they can only write repeat prescriptions) and would support a similar approach for community nurse prescribers\[^{19}\] (181, PHARMAC).

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\[^{15}\] Some medicines are only subsidised if prescribed by a specialist doctor. Other medications may be subsidised if a specialist has recommended the treatment for a specific patient. The prescriber must write on the prescription the name of the specialist and the year of the recommendation. These recommendations are valid for two years and can be renewed by a further consultation.

\[^{16}\] Special authority criteria define the patients who can receive funding for a particular medicine. Often patients are required to undertake a trial of a less expensive medicine or the medicine may need to be prescribed by a defined specialist.

\[^{17}\] The advice from Family Planning was that some patients may pay the full price for this treatment.

\[^{18}\] Please note that the Nursing Council delayed its consultation by two months to enable PHARMAC to review the medicines lists.
There will be certain situations in which a special authority to prescribe should be available to a nurse. In child health, for instance, a suitably qualified nurse should be able to diagnose and treat milk allergy and prescribe amino acid based formulas (such as Elecare or Neocate) using a special authority (185, Royal New Zealand Plunket Society Incorporated (Plunket)).

PHARMAC stated that just because a medicines list may be approved for designated nurse prescribers it did not guarantee these prescribers would be able to apply for special authority medicines.

As the Nursing Council is aware, PHARMAC is required to consult publicly and decide on any changes to the designated prescribers who are authorised to access public subsidies. If the PHARMAC Board approves the subsidy of pharmaceuticals for one or both of the above, this does not automatically mean that these prescribers will have access to apply for Special Authority approvals, either manually or electronically (181, PHARMAC).

5.8.6 Inappropriate medicines listed

Many submitters were concerned about the inclusion of immunosuppressants – methotrexate and cyclosporin. Others were concerned that medicines were included that required close monitoring of a patient’s condition (13, 57, 97, 99) and/or blood results (21, 97, 127).

We believe that this list includes medications that does not fit with the treatment of “minor ailments” and require close monitoring and laboratory testing by an authorised prescriber, for example, methotrexate. We would urge that if this level of prescribing was to be approved that this list must be reviewed (57, District Health Board).

From an anaesthesia perspective, the NZNC has significant concerns with the inclusion of the drugs that are not commonly used, for example ergotamine; outdated, such as chloroform; and drugs which can present significant safety risks if not used appropriately, such as atropine (114, New Zealand National Committee of the Australian & New Zealand College of Anaesthetists (ANZCA)).

Other submitters commented that there were some medicines listed that were not commonly used or outdated (60, 114), not funded (60, 127), not available in NZ (60, 127) or not on the pharmaceutical schedule (98, 179, 187).

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19 Personal communication with PHARMAC staff indicated that PHARMAC may review its position on restricting the prescribers who can apply for special authority, including diabetes nurse prescribers. If PHARMAC maintained the same position then nurse prescribers could repeat prescribe.

20 Chloroform was included as an extemporaneous item and atropine is an ingredient in diastop an antidiarrhoeal medicine.
5.8.7 Importance of nurse prescriptions being subsidised

Some submitters pointed out the importance of PHARMAC subsidies to achieve benefits for patients from the proposal (185).

In order that clients are not discriminated by accessing nurse prescribers, the Pharmac subsidies afforded to medical practitioners would need to apply equally to nurses (185, Royal New Zealand Plunket Society Incorporated (Plunket)).

Prescribing is prescribing – and the same level of subsidy needs to exist for nurse prescribing as there is for other prescribers, otherwise nurse prescribing will be limited to those who can afford to pay non-subsidised medication costs. This does not support faster and more convenient access – and may in fact mean that patients chose to seek out other prescribers (e.g. Emergency departments) where costs do not apply (148, Government Agency).

5.8.8 Incorporate best practice

Two submitters saw an opportunity to incorporate current best practice in prescribing within the list (38, 86).

A number of the proposed medicines are not considered to be appropriate choices according to current best practice. Most prescribers will “self-regulate” and not prescribe meds they are unfamiliar with but with a new group of prescribers it is a good opportunity to eliminate poorer or higher risk choices. It will help new prescribers make good choices by excluding less appropriate medicines, also it is easier for nurses to learn about a smaller number of medicines and not waste time learning about irrelevant medicines (86, CAPA - Clinical Advisory Pharmacists Association).

5.8.9 Concerns about antibiotics

Some submitters were concerned about the inclusion of antibiotics that are not first line (60, 86, 138, 150) or have resistance issues (107, 110, 181). One submitter was also concerned about the inclusion of disinfectants (110).

Concerns from the Infection prevention and Control CNS group:
The infection prevention and control nurses specialists have significant concerns with the range of antibiotics and other antimicrobial agents that are listed. We believe that the ‘Community Nurse prescribing qualifications, experience and training would NOT be enough to provide the in depth knowledge of antimicrobial therapy required to prescribe sensibly. Worldwide there is a large body of work going on in healthcare on antibiotic stewardship and sensible antibiotic prescribing to try and minimise the amount of antibiotic resistance we
have in the world. In addition the prescribing of certain types of ABs leads to Clostridium difficile infection which is going to be the next major problem for our healthcare facilities when the outbreak strains get established within our country. There are also disinfectants listed that are known to promote resistance (110, Group of Nurses, CNS).

The list of antibiotics should be limited to first-line medicines which do not require a specialist recommendation. Highly controversial use (86, CAPA - Clinical Advisory Pharmacists Association).

PHARMAC has a role in supporting the appropriate use of antibiotics. In addition to this, PHARMAC is currently working with the Ministry of Health on the Rheumatic Fever Prevention Programme. One of PHARMAC’s key roles is to propose and develop a nationally consistent approach regarding the provision of antibiotics under this programme. PHARMAC considers that any initiatives to widen access to antibiotics need careful consideration with national oversight due to the risks associated with misuse including, over and under-use.

Part of our concern is not only related to the products themselves, but the risks associated with insufficient prescriber knowledge of contra - indications, multiple condition management etc. So while some medications may be within a nurse’s scope of practice for particular conditions, what is unclear is whether the training provided is of a suitable standard to enable nurses to manage issues associated with multiple condition management. A six day course appears (to us) to be insufficient for this (181, PHARMAC).

5.8.10 Clarify the route of administration and specify repeat prescribing for some items

Suggestions were made to clarify the list by adding the route of administration21 (41, 91, 114, 116, 127, 187).

We recommend the Council consider including the model of delivery as this may have an influencing impact on patient safety (116, Non-Government Organisation).

Specifying repeat prescribing rather than initiated, by community nurse prescriber was also seen as an option for some items on the list (27, 41, 91, 114, 166, 176, 181, 183, 185, 190) or there be a requirement that the nurse consult with a general practitioner or an authorised prescriber (38, 46). Others thought all the prescribing should be collaborative (41, 116).

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21 The Nursing Council used Medsafe terminology for the list of prescription medicines and was advised that it could not specify route, strength or any other circumstances related to the prescribing of the medicine.
There should be two separate lists of medicines- those which can be prescribed as repeat prescriptions once initiated by the patients’ doctor and then a separate list of medicines which are able to be initiated by a prescribing nurse (176, Individual Pharmacist).

Identify medicines that can be prescribed by nurse prescribers with additional advanced training, ongoing education and, where necessary, specialist support

- Ensure that the list of medicines includes details of administration methods
- Differentiate medicines that can be prescribed by a nurse who is initiating treatment, from those medicines that can be prescribed for maintenance of treatment where the diagnosis and initiation of treatment is made by a medical practitioner (114, New Zealand National Committee of the Australian & New Zealand College of Anaesthetists (ANZCA)).

There may be some medications required in community, in this instance the RN may be required to consult with the GP/NP recommendations for some drugs they wish to prescribe (38, Individual nurse).

The level of knowledge and understanding of pharmacokinetics/ pharmacodynamics, and pharmacology will be inadequate for this list of medicines. The nurse prescriber should have a specified list monitored by the medical prescriber (86, CAPA- Clinical Advisory Pharmacists Association).

5.8.11 Develop focused lists for specific areas

Twelve submitters suggested having focused lists for areas within community/primary nursing (81, 109, 117, 129, 144, 148, 153, 157, 161, 175, 181, 171). Others suggested an individual contracted list (11, 42) or to only prescribe within a specific area (166).

This is far too many across far too many fields. They need to be grouped therapeutically and candidates should need to specify/sign up to competence in one or more therapeutic groups - our diabetes nurses would not be expert in COPD for example. Including OTC medicines would be entirely appropriate if funding/access issues can be overcome (129, Individual Doctor).

We consider the list of proposed medications to be complex and very broad. Our suggestion is that as a starting point, sub- lists of medications are applied to the different areas of clinical practice, e.g. Ear Nurse, Sexual Health Nurse, Aged Residential Care, and Primary Care. These lists would form the basis of protocols for practice within these practice areas and could be regularly reviewed and updated as clinical practice develops and changes (148, Government Agency).

It is suggested that nurses working in specific practice areas such as District Nursing, Practice Nursing, School Based Nursing, Stomal nursing etc. would define and consult on a list of medications that are relevant for the area of practice. These lists would most likely contain low risk medications and medications specific to the area of practice. District Nurses
would in the main meet the definition of "community prescribers" however their practice may span into the Specialist prescriber domain. E.g. needles, insulin syringes, glucose testing strips, ketone testing strips. Some analgesics from the “Specialist” list would also be appropriate for DNWs working with general palliative care clients.

Some other suggested “focused” lists from the formulary could include:

- School based nurses: panadol, loratadine, ibuprofen, ECP, respigen/ventolin inhalers and topical OTC creams
- Stomal nurses: Steroid lotions, Enemas, loperamide, laxatives, antifungal sprays or powders.
- Infusion nurses: Adrenaline, Heparin, Antihistamines, Alteplase / Actylase.

Formularies for specific practice areas should be agreed by the employing agency and set out in policy documents. While there are issues with the list not suiting all nurses, the policies and procedures of the organisation will provide the assurance that the nurses have the required education and the audit oversight to maintain safe practice (153, Nurse Maude Association).

Nurses who work in specific areas should be able to prescribe drugs they are familiar with in their daily work and not have access to the whole list (144, Group of Nurses, Community Health).

5.8.12 Suggestions for finalising the list

One submitter suggested only medicines for which there are standing orders (102, 121). Another submitter suggested starting with a small list and then increasing it over time (60), while others suggested restricting the list (54, 74, 81, 105). Other submitters were concerned that the list could be regularly updated (6, 11, 33).

The Guild recommends that a small formulary is developed initially (similar to how the UK developed their formulary in stages), and that it is reassessed at a later stage (60, Pharmacy Guild of New Zealand).

Others thought the list should be reviewed by groups of nurses working in schools, general practice or district nursing (59, 75, 111, 153), or by specialist groups (114, 197).

It is suggested that nursing areas of practice should develop their own set of commonly prescribed medications—this could be undertaken through the various interest groups such as the NZNO Primary Health Care nurses group for example (153, Nurse Maude Association).

ANZCA’s NZNC would be most willing to participate in the development of medicines lists appropriate for safe, high quality practice, improvement of patient outcomes, and which support the safety of the health professionals involved (114, New Zealand National Committee of the Australian & New Zealand College of Anaesthetists (ANZCA)).
What is really refreshing is to see a list of medications which is comprehensive but adaptable according to scope of practice and individual skills…This is interesting. The Devil in the Detail. I feel that this area needs considerable additional work and it is not yet ready to be approved….I shall return the problem of the prescribing list to you: Ask yourselves, in what way does access to this medication help the aims of better, sooner, more convenient care? Are there any reasons NOT to permit this medication to be prescribed by nurses (don’t forget societal impact). Do the benefits outweigh the hazards? At the risk of labouring the point about vitamins, does this medication being prescribed imply an underlying medical condition that requires medical input? Also, do not underestimate the ability of the human being to get the wrong end of the stick about medication, especially placebos. You run the risk of institutionalising the use of placebo medication such as cough mixture and thus increasing rather than reducing the burden on the health system. Perhaps nurses should be the first group to eschew publicly the use of medication with no proven value (61, Individual Doctor).

Some submitters wanted classes of medicines removed from the list: (local) anaesthetics (85, 186), antiemetics (85), antibiotics (85, 86), quinilones (107, 150), antineoplastics (85, 86) and steroids (85), retenoid therapy (31, 85), vitamins (20) and some NSAIDs (20, 21).

Some submitters wanted to add medicines to the list. These included immunisations (58, 141, 178) and salbutamol.

…All vaccines need to be included in the list of medicines. We would recommend the wording to be inclusive of “all New Zealand (NZ) National Immunisation Schedule (NIS) vaccines, vaccines recommended by Ministry of Health (funded and unfunded as per the Immunisation Handbook and subsequent MoH notification), oxygen and adrenaline”, rather than individually list the vaccines available in the NZ; therefore, as new vaccines are added or changed the list would not need to update…that the NCNZ consider including a change to the “Authorised Vaccinator” process to enable Registered Nurse to administer vaccines, oxygen and adrenaline after completion of vaccinator training

- 16hr theory
- written learning assessment
- clinical assessment with an approved assessor
- an endorsement on their practicing certificate as a “certified vaccinator” by NZNC

We propose a change to the wording; explicitly include “all New Zealand (NZ) National Immunisation Schedule (NIS) vaccines, vaccines recommended by Ministry of Health (funded and unfunded as per the Immunisation Handbook and subsequent MoH notification), oxygen and adrenaline administered by a RN on completion of the Authorised/Approved/Certified Vaccinator process” as outlined above, and removing the need for application to the Medical Officer of Health (141, Immunisation Advisory Centre).22

22 NIS vaccines were considered for the list but as nurses are able to administer these under the present Independent Vaccinator provisions of the Medicines Act, and education and competence requirements are already in place, this area was not included.
5.8.13 All nurses should be able to prescribe OTC medicines

The suggestion was made that all nurses should be able to prescribe OTC medicines (61), that there should be a freeing up of OTC medicines (178) or that nurses should be able to access the PSO or be able to prescribe OTC medicines (155).

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 (178, Pharmaceutical Society of New Zealand).

An alternative option for increasing nurse prescribing and improving access could be extending the restricted medicines (as opposed to prescription medicines) that nurses are able supply. The advantage to this option is that it restricts prescribing by indication, as well as by pharmaceutical (181, PHARMAC).

Many school nurses are currently ECP endorsed with NCNZ however have difficulty obtaining the medication. Being able to prescribe ECP would overcome this issue\(^{23}\). Alternatively having access to MPSO. Salbutamol (Ventolin) can be purchased at pharmacies. It would be ideal for nurses working in school clinics to be able to prescribe medications that can be purchased from a pharmacy (155, Auckland School Nurses Group).

5.8.14 Other comments

Other comments made related to the impact on the pharmaceutical budget (107), concern that the Council had only consulted on an ‘indicative list’ (114), that mental health medicines were not included (64) and that listing the ingredients in medicines is not helpful (178).

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 (178, Pharmaceutical Society of New Zealand).

\(^{23}\) Some nurses can administer and dispense ECP but they must have access to the PSO in their workplace or else the patient pays the full cost of the medicine.
5.9 Non-prescription medicines (Question 1.11)

The Council proposed a list of non-prescription medicines that would 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 if this was agreed by PHARMAC.

A large majority of submitters (85%) agreed that community nurse prescribers should be able to access the proposed list of non prescription medicines (see Chart 5, page 52).

Many clients in the community think it’s daft that the nurse assesses and diagnoses and can explain to the client the required treatment, which they then have to go to a GP to get. Or that they can get medicated treatment over the counter but at triple the cost, than if they get it on script e.g. treatment for scabies, head lice (37, Individual Nurse).

5.9.1 Support for the list of non-prescription medicines

Reasons given for supporting the list were that these medicines were perceived to be low risk, could be obtained from a pharmacy without a prescription anyway and had the potential to make a real difference to patients who cannot afford them i.e. to address inequity of access to health care (14, 37, 74, 97, 98, 105, 109, 126, 140, 155, 156, 158).

These medications are deemed to be low risk by PHARMAC and medsafe and therefore can be used in a judicious manner to make health care and medications more accessible (97, Individual Nurse Practitioner).

Anyone in the community is able to access this list, the advantage of prescribing is the cost to the patient (74, Group of Nurses).

Yes. Entirely appropriate that a community nurse prescriber could prescribe what a patient is able purchase over the counter. It is felt that this list contains some of the items which they would be seen prescribing on a daily basis (98, NZNO (Diabetes Nurse Specialist Section)).

Absolutely; for public health nurses this would be the most significant category for their clients, the siblings and families. Convenient, timely; topical treatment of scabies and skin infections will prevent GP presentations, ED presentations and hospital admissions. The value for these children will be in the relief of itching and pain, disruption to sleep and schooling and the known incidence of secondary infection sometime s requiring hospitalisation and also development of glomerulonephritis with its potential for long term kidney damage (37, Individual Nurse).

We agree this will be helpful to consumers on limited incomes (14, Women's Health Action).

Yes it would make for more compliance with clients meeting their needs e.g. assisting the children with eczema who parents continually run out of treatment and will not treat there children because of GP costs. Food is more important (105, Individual Nurse).
5.9.2 The importance of subsidies for non-prescription medicines

Some cautioned that little would be gained if the patients of nurse prescribers did not get subsidised medicines and they should have the same as other prescribers (59, 75, 80, 111, 178).

Being able to prescribe medicines on the non-prescription list and for this group of nurse prescribers to have prescriptions covered by the Pharmac subsidy is highly desirable, little is gained in terms of patient accessibility to medicines if they then have to pay the full price particularly as many patients may not be able to afford the cost (75, Primary Health Care Leadership across Waitemata and Auckland districts).

5.9.3 Nurses need access to the PSO

Also there was concern that the prescription charges would continue to be a barrier so nurses need access to an MPSO (155).

With cost an issue for many our young people, any means to reduce cost is an advantage. Prescription charges will continue to be a barrier for many of our high needs families. Access to MPSO would be useful as well as many clients are unable to meet prescription fees. Young people are often not able to get transport to pharmacy, so to have the medication on site at the school clinic removes the barrier of further cost and transportation (155, Auckland School Nurses Group).

5.9.4 Inappropriate medicines on the list

A few submitters thought the list was too broad (41) or that particular medicines should be removed as inappropriate or because they were not subsidised24 (85, 107, 128). This caution extended to OTC items on the prescription list.25

I agree that there should be a non prescription medicines list but not to this list. Are these a list of non prescription medications that would be subsidised if a nurse prescribed them? If so, I think there may be some confusion, as many of the ingredients on the list are not subsidised on a prescription. Condoms, other contraceptives and pregnancy tests are the only reasonable items on this list (107, Individual Pharmacist).

Many non prescription medicines and many prescribed over-the-counter medicines listed are not funded in any manner. It is unclear, and there may be some misunderstanding, over

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24 The Council agrees that “a wish list” of many unsubsidised items was included in the non prescription medication list. The decision to subsidise any non prescription medicines for community nurse prescribers would be PHARMAC.

25 Some OTC medicines become prescription medicines at a certain strength. So if they were included on the prescription list they were not included on the non prescription list.
how nurses described in the proposal will seek to attract funding for these medicines. Similarly it is unclear how community nurses prescribing non-funded medicines improves outcomes for patients since in many cases the medicine cost is a barrier for patient access (85, Pharmacy Council of New Zealand).

It was suggested that activated charcoal and potassium be removed.

**5.9.5 Add non-preservation medicines**

Some submitters wanted items added to the list, particularly diabetes and asthma devices that were listed on the specialist nurse non-prescription list (147, 153).

- Would like the list expanded to include such non-prescription medicines such as glucose test strips, spacers, peak flow meters, etc. This would greatly enhance their role.
- We trust it will assist in addressing some barriers of inequitable health care access.
- It would be fantastic if all registered nurses were able to provide condoms (147, Rural Canterbury Primary Health Organisation).

A considerable number of medicines in the Specialist Nurses non-prescription list would be appropriate to include in the Community nurse non-prescription list e.g. peak flow meters. Spacer devices, blood glucose diagnostic strips (41, Primary Health Organisation).

Submitters suggested a few other items to be added. Some are on the prescription medicines list or the non-prescription list under chemical name (ural, artificial tears, calmurid) or are not funded (Waxsol, Vosol). One suggested that crotamition is a prescription item not included on either list which could be included.

**5.9.6 Cost of the proposal**

A few submitters cautioned that this proposal may be costly (20, 21, 178). A suggestion was made for this prescribing to target certain communities (21).

I agree the community nurses should have access to a non-prescribed medications list, this could increase their capacity to reduce the financial cost to patients, making specific medications more accessible and to those in need i.e. Contraception advice and prescription to young teenagers. An opportunity exists to provide a more comprehensive educational discussion on use and benefits of the non-prescribed medicines to specific communities (21, Individual Nurse).

One submitter considered there were significant issues with the lack of subsidies for the medicines that community nurse prescribers might use (OTC and prescription items) and any change to the subsidies would increase the pharmaceutical budget.
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 (178, Pharmaceutical Society of New Zealand).

5.9.7 Regular review of the lists

Some submitters questioned the process for updating the lists.

It would be useful to know what the intended process is for updating this and the other lists? What would the proposal be, for example, when PHARMAC subsidises something that is not currently on the list and perhaps should be (181, PHARMAC)?

5.9.8 Reasons for disagreeing with this question

One submitter believed the right to prescribe should be confined to prescription medicines (62). Another submitter did not agree with the proposal (173) and two others did not agree with the length of education proposed (79, 100). One submitter commented that nurses are unable to diagnose (86).

Many of these medicines will require a clear diagnosis which is outside the realm of nursing (86, CAPA - Clinical Advisory Pharmacists Association).
6 Proposal Two: Specialist nurse prescribing

6.1 Proposal for specialist nurse prescribing (Questions 2.1 and 2.2)

The Council proposed 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.

There was a high level of support for the Council's proposal (see Chart 6 below).

Chart 6: Support for specialist nurse prescribing proposal

6.1.1 Support for the proposal

A large majority of submitters (93.6%) agreed with the proposal that suitably qualified and experienced registered nurses be able to prescribe from the specialist and community nurse prescribing lists of medicines.

We agree that facilitating nurse prescribing will provide workforce flexibility and improve outcomes for New Zealanders (72, Family Planning).

The benefits will be earlier access to medication and health advice, reducing the likelihood of complications that may require more serious health intervention. It will also extend nurse competency to a higher level. It should also allow doctors to attend to more urgent cases (124, New Zealand Home Health Association Inc.).
It could also reduce the burden on inpatient length of stay, GP clinics and specialist physician clinics, as well as reducing the financial burden on patients who struggle to attend appointments and/or pay for repeat prescriptions from their GP (164, Group of Nurses, DHB).

There was more support for this proposal from some medical groups.

There was support for designated prescribing only if the nurse has appropriate experience in specialist setting. From the information given this is the appropriate model for nurse specialists (135, Council of Medical Colleges in New Zealand).

The College understands that the proposed expansion of registered nurse prescribing has the potential to:
- Increase patients’ access to treatment, particularly in rural and remote areas
- Provide one solution to workforce shortages. Nurses practicing in rural settings may be the primary health provider; therefore the nurse prescriber will play a valuable role as a conduit between ‘hard to reach patients’ and health services.
- Improve the efficient delivery of treatment. For example, the current use of standing orders is not an efficient way of delivering treatment. Signing off standing orders is a time-consuming process for medical practitioners. Therefore, the options for a new scope of practice for specialist nurse prescribers, or an addition to the registered nurses’ scope of practice to allow specialist nurse authorised prescribing, represent opportunities to improve nurse-patient and nurse-doctor interactions and provide clear accountabilities for nurse prescribers (189, The Royal Australasian College of Physicians).

…the College gives qualified support to specialist nurse prescribing insofar as the proposals are restricted to nurses with advanced skills and knowledge and these nurses would work as part of a collaborative multi-disciplinary team (194, The Royal New Zealand College of General Practitioners).

6.1.2 Benefits to patients

The Council proposed that prescribing authority for specialist nurses would mean 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.

The majority of submitters (94.3%) agreed that specialist nurse prescribing will enable patients to receive more accessible, timely and convenient care.

Most submitters who commented supported the statement that specialist nurse prescribing would lead to patients receiving more accessible, timely and convenient health care (13, 53, 77, 85, 124, 125, 138, 145, 149, 154, 175, 180). Some thought it would result in a reduction
in unnecessary admissions and presentations to emergency departments (13, 20). Others noted benefits for patients in rural and remote areas (180, 189).

In the General Practice setting, Nurse Prescribing enables all issues to be addressed and dealt with at one consultation, even when conferring with the GP is necessary. It saves two appointments to go over the same ground, sometimes also easier to see the Nurse than the GP because of time constraints. So convenient and safe (125, Group of Nurse Practitioners).

The diabetes nurse prescribing model is an excellent example of specialist nurse prescribers helping ensure more accessible and timely care for patients. Working under supervision and in partnership with medical practitioners, diabetes nurse specialists have improved continuity of care for patients, reduced the need for separate appointments for routine prescriptions and reduced pressure on other prescribers (85, Pharmacy Council of New Zealand).

Other submitters reported benefits to nurses, doctor and the organisation. Examples were given of nephrology (54, 179), ENT (145), pain (73), ophthalmology (113) and hypertension clinics (24).

With the increasing aging population adding to the growing numbers of patients with glaucoma, diabetes and age related macular degeneration Ophthalmologists clinics are now loading up with patients who are stable but require frequent ongoing observation with occasional adjustment of their medications. This means that new patients and complicated patients do not have as much access as they require. A nurse working in an expanded role with the scope to include prescribing would be able to review those patients who are stable thus relieving some of the burden from such clinics (113, Individual nurse).

We have a well-established Hypertension Clinic at Waitemata DHB whose model of care depends importantly on autonomous nurse-led clinics. At these clinics, hypertension drugs are titrated according to algorithms. Currently a doctor needs to sign all the prescriptions, but it would considerably facilitate the system if routine medicine-prescribing was done by the Hypertension Nurse-Specialist (24, Individual Doctor).

Some submitters thought nurses were doing this already (55, 64, 72, 77, 110).

Very important given extensive waiting lists. Nurses often having more flexibility with their time. Many nurses engage in de facto prescribing now, taking the history and undertaking assessment and then presenting the case to the doctor and often making recommendations on what prescription could be provided by the doctor, with their agreement (64, Individual Nurse).
A few submitters observed that the proposals would not address some of the barriers to health care for some patients (3, 48, 67, 156).

These proposals will not address the fundamental barrier of cost for young people and their whanau to attend general practice or to collect their prescriptions. Prescription charges will continue to be a barrier for some in our community. Beneficial to schools that have visiting asthma nurse educators who can prescribe and therefore remove need to visit GP for repeat scripts (156, CMDHB School Health Awareness Raising Group (SHARP)).

Not necessarily. The patient still has to make an effort to see a nurse as opposed to a Doctor (3, The Pharmacy Defence Association of New Zealand (Inc.)).

...Due to the private business model of a large proportion of PHC in NZ there is no certainty that the patient will be able to access care by the specialist nurse prescriber. There may need to be a redistribution of capitation funding to allow the patient direct access to a cheaper provider such as the specialist nurse prescriber. For example, Nurses in a GP setting may be supported by the employer to become a specialist nurse prescriber but the patient may still be paying a large prescription or visit fee to see the nurse to obtain the script. A GP setting is ideal for enhancing the role of the specialist nurse prescriber within a collaborative multidisciplinary team (48, Individual Nurse).

Some of those who did not support the proposal raised issues related to the safety of nurse prescribing (69, 97, 100, 104, 143) and some medical groups would prefer to see a model of delegated prescribing (69, 186, 194) (see comments on page 24).

The Council of Medical Colleges gave qualified support for specialist nurse prescribing to be designated prescribing.

There was support for designated prescribing only if the nurse has appropriate experience in specialist setting. From the information given this is the appropriate model for nurse specialists.

Therefore in terms of extending designated prescribing it was suggested that:
- Any new prescribers should have training, a formal qualification and practical, “hands on” experience in the specialist area. Appropriate prescribing requires time learning via observation (as well as knowledge of pharmacology and diagnosis) similar to the way medical practitioners learn via an apprenticeship model.
- Adequate mentoring systems by experienced prescribers are needed for designated prescribers, preferably with mentoring by medical practitioners.
- Supervision of prescribing practice should be ongoing rather than for only six months.
- Prescribers should ensure they maintain their competency via ongoing continuing professional development, with monitoring by the Council at least every three years
- The public would be better informed about the nurses’ extended prescribing ability via a specific scope of practice rather than use of authorisation under the HPCAA section 22 (135, Council of Medical Colleges in New Zealand).
6.2 Title for specialist nurse prescribing (Question 2.3)

The Council proposed the title “specialist nurse prescribing” for this level of nurse prescriber. About half of submitters (50.8%) supported the title “specialist nurse prescribing” (see Chart 7 below.)

**Chart 7: Support for specialist nurse prescribing title**

6.2.1 Specialist nurse prescribing title too confusing

One of the reasons given for not supporting the title was that it would be too confusing especially with clinical nurse specialist and specialty nurse roles. Others thought the title was confusing or misleading because it implied the nurse would be working in a specialist area (5, 17, 39, 43, 52, 57, 60, 61, 83, 84, 91, 110, 123, 124, 130, 131, 132, 147, 149, 153, 178, 180, 182, 187).

> There is concern that this title will become confused with other 'nurse specialist' titles, therefore potential for role confusion. Also potential for patients/clients and/or other health professionals to assume a nurse with a nurse specialist in their title can/will prescribe (147, Rural Canterbury Primary Health Organisation).

> The title gives the impression that a “specialist” nurse will be providing only a few medications for a specific condition (110, Group of Nurses, CNS).

Some submitters thought there was a lack of consistency in education or skill level for nurses with similar titles, i.e. specialist nurses and clinical nurse specialists (39, 52, 88, 162).
There is no national framework or regulation around the role and scope of practice of a nurse specialist therefore the use of the term nurse specialist is open to interpretation (52, Group of Nurses).

Others were concerned that the term specialist did not infer a generalist or population-based role or was not used in primary care (59, 75, 80, 111, 178). Others mentioned the possibility of title confusion with a medical specialist (59, 75, 80, 111, 178).

Suggest review of title. Using the term ‘specialist’ may be confusing as there are some medicines that only an authorised medical specialist may prescribe.... The term specialist does not infer population based care –is very specific. Suggest a glossary of terms to provide clarity: Titles in secondary care sector appear to differ to those in primary care sector or community (75, Primary Health Care Leadership across Waitemata and Auckland districts).

6.2.2 Suggested titles

Fourteen submitters suggested adding the specialty area to the title (20, 21, 52, 79, 85, 93, 124, 139, 145, 150, 163, 166, 179, 190).

Would like to see the addition of the specialist area added e.g. Outreach specialist nurse, Specialist Practice Nurse (190, Te Awakairangi Health Network Clinical Governance Committee).

Fifteen submitters favoured registered nurse or nurse prescribing/prescriber, or simply an endorsement on their practising certificate (57, 60, 83, 110, 122, 123, 130, 131, 132, 137, 149, 151, 175, 182, 187).

The title should be RN with authority to prescribing to enable nurse with preparation at nurse specialist level (PGdip) who work in community or schools or primary health settings to prescribe within their area of practice (83, Individual Nurse Practitioner).

Twenty-six submitters suggested either a category of prescriber be used or Level 2 prescribing (34, 36, 57, 59, 73, 75, 111, 123, 124 130, 131, 132, 138, 149, 151, 153, 158, 180, 182, 187). Others raised concerns that the title should primarily provide employers with clarity (57, 122, 130, 131, 132, 149, 182, 187).

If Council was to proceed with the two types of prescribing we believe that it needs to be more clearly defined as 2 levels e.g. category 1 & 2, nurse prescriber and advanced nurse
Specialist title is too confusing with existing nursing roles and does not describe the settings where the nurses may work etc. We suggest the focus remains on the level or class of prescribing. However, if there was to be only one level then the title RN Prescriber would fit well. It is important that this title clearly describes the role for employers, rather than the public who are unlikely to understand. Employers need clarity, public less concerned or able to understand the complexity (57, District Health Board).

A few submitters suggested variations on the specialist nurse prescribing title such as specialist prescribing nurse (170), specialist nurse prescriber (25) or nurse specialist prescriber (129, 137). Other suggestions were registered nurse advanced prescriber or advanced registered nurse prescriber (27, 84, 138, 178). Four submitters favoured delegated prescriber (75, 80, 86, 111), one designated prescribing (55) and one primary health nurse prescriber (158). A few submitters suggested there was a need to reduce public confusion and to educate the public (98, 159, 179, 188).

Extensive public education would be required to ensure the understanding of the title is well embedded. As well as amongst health care providers, there is confusion/ misunderstanding already regarding Nurse Practitioners. In order to work successfully a major advertising campaign would be required (179, MidCentral District Health Board- Nursing).
6.3 Work as part of a collaborative, multidisciplinary team (Question 2.4)

The Council proposed that nurses with specialist nurse prescribing authority work as part of a collaborative, multidisciplinary team, and manage and monitor patients with these conditions in clinics or by providing home-based care. They would seek assistance from a doctor within the team when making difficult or complex clinical decisions, or refer a patient who has a health concern or complexity which is beyond their level of competence to a doctor.

Nearly all submitters (94.2%) agreed that nurses with specialist nurse prescribing authority should be required to work in a collaborative, multidisciplinary team. Twenty submitters commented that this was essential or supported safe prescribing (6, 39, 53, 55, 59, 68, 75, 80, 98, 99, 101, 110, 111, 114, 134, 159, 179, 189, 195, 196).

Working in a collaborative multidisciplinary team as a specialist nurse with prescriptive authority provides a good governance structure, resources and defined channels of communication regarding prescribing and medication management decisions. It also provides clear support for patient referral if the patient condition is outside the scope of the nurse’s practice/competency (53, Nursing and Midwifery Board of Ireland).

Five submitters believed the nurse should be required to work with a medical practitioner rather than a team (61, 86, 99, 150, 181).

The term multi-disciplinary could reflect a very wide range of health professionals (e.g. allied health staff) whereas we assume the requirement here is that these nurses are to be working in a practice with specialist medical staff (181, PHARMAC).

MDT—please define. I should prefer to see this dropped in favour of a requirement to work in a collegial relationship with a doctor or doctors specified. MDT is a rather meaningless term in this context (61, Individual Doctor).

Another four submitters wanted working as part of an MDT to be defined especially for nurses in rural areas (27, 61, 74, 140). Nine submitters raised issues concerning nurses working in rural and remote areas and how they might meet these criteria (58, 91, 98, 141, 147, 151, 170, 175, 179).

Define collaborative multidisciplinary team working—to ensure isolated practitioners are not disadvantaged (27, Health Care Development).

No- Nurses in some specialties do work in isolation e.g. rural nurses or work autonomously and less overtly in a MDT. It would limit their ability to provide a service to have requirement
for a close MDT environment. Contact with MDT would need to be defined- daily, weekly, monthly, in person, by email (74, Group of Nurses)?

There is concern for those nurses practicing in very rural/isolated areas of how participating as part of a collaborative multidisciplinary team would occur, and also how a minimum of 6 months supervision would work. Perhaps rewording ‘required to work in a collaborative multidisciplinary team’ to ‘have a collaborative working relationship with a multidisciplinary team’ may be more enabling particularly for those nurses working rurally (179, MidCentral District Health Board - Nursing).

Submitters commented on the need for ongoing case review and audit (26, 41, 98, 147, 179, 190).

On-going engagement within a collaborative multidisciplinary team is important for this model to work successfully long-term. An extensive supervised period with on-going case review at regular intervals to support the nurses prescribing decisions and confidence is an absolute must (98, NZNO (Diabetes Nurse Specialist Section)).
6.4 Practise under supervision for six months (Question 2.5)

The Council proposed that nurses with specialist nurse prescribing authority have a condition in their scope of practice that they must prescribe under supervision for six months. Most submitters (91.6%) supported nurses with specialist nurse prescribing authority being required to practise under supervision for six months when they begin to prescribe.

Thirty-five submitters made comments that supported this proposal (3, 4, 10, 11, 13, 14, 19, 20, 21, 24, 35, 39, 40, 44, 48, 49, 53, 54, 55, 56, 67, 76, 77, 78, 104, 121, 130, 131, 132, 151, 164, 173, 177, 182, 189).

Mentoring and coaching is an essential element to learning within the primary setting (11, Whanganui Regional Primary Health Organisation).

We do support a period of supervised prescribing practice as it is clear from the literature about novice prescribers that they benefit from the support of a prescribing colleague (121, Massey University).

Eleven submitters commented that the practicum was enough (12, 15, 59, 61, 75, 92, 94, 133, 142, 150, 169).

As part of my Masters of nursing I am doing a prescribing practicum which is one year duration. After completing this I am then expected to complete another 6 months supervision? If a prescribing practicum has not been completed then yes 6 months is reasonable (12, Individual nurse).

The nurse has completed a supervised practicum. The nurse will need access to someone for review of ongoing professional practice but not supervision. Guided by scope of practice (75, Primary Health Care Leadership across Waitemata and Auckland districts).

Two submitters commented that the requirement should be the same as in the nurse practitioner programmes (66, 106).

I think this time frame should be aligned with the prescribing practicum within Nurse practitioner pathway, as one programme could be seen as an ‘easier’ option (66, Individual Nurse).

Another commented that the nurse is already working closely with doctors (145).
Most nurses in specialty roles now are working closely with Consultants / Doctors, this will give them continued access to discuss decision’s – obtain feedback in a new area of practice – any unforeseen difficulties can be dealt with (145, Individual nurse).

Some medical groups stated that supervision should be ongoing (135, 143).

Education of and supervision for nurse prescribers is a critical issue. Prescribing is complex and to safely prescribe the drugs listed in the consultation document, some of which are complex in their effects and side-effects, formal education needs to be comprehensive and supported by a significant amount of supervised clinical experience - much like a medical degree. A ‘safe’ amount of knowledge cannot be acquired over a short period of time. The proposed training for community nurse prescribers of six theory days and three days of supervised practice is certainly not sufficient. While the proposed postgraduate diploma for specialist nurse prescribing does cover more content, it is unlikely to cover the complexities of prescribing within a specialist mental health setting. Supervision of prescribing should be ongoing rather than just for six months, and include mentoring and monitoring by experienced prescribers. This will have an impact on services (143, The Royal Australian & New Zealand College of Psychiatrists).

Two submitters commented that three months’ supervision was sufficient (80, 119), whereas six others commented that 12 months was necessary (23, 36, 125, 147, 148, 196).

We feel that with the limited education and training the RN prescriber would benefit from a full 12 months of supervision. It is problematic for nurses already prescribing in the community to complete adequate supervision as they may have few peers within their work environment. There will need to be a formalised process to support these nurses, including funding protected time with the clinical supervisor and a system approach for evaluation of prescribing similar to that of general practitioners via the PHO or employing organisation (36, NZ College of Primary Health Care Nurses, NZNO).

The group have a level of concern that six months supervision for specialist nurse prescribers is too short a period. There is evidence that shows that most RMO prescribing errors occur in year 2 when their confidence in prescribing has grown and results in over-confidence. Is there evidence, from nurse prescriber roles where a similar training programme and 6 month period of supervision has been used, that shows that there is no increase in adverse outcomes or prescribing errors in the following two year period (148, Government Agency)?

Four submitters believed supervision requirements could be determined on a case-by-case basis (42, 57, 112, 150).

Four submitters raised the difficulty of obtaining supervision for rural nurses and suggested a longer time period may be required (26, 151, 168, 180).
Nurses in rural practice may find the 6 month time frame too short to get sufficient prescribing practice supervision. These isolated nurses might find accessing the appropriate ‘MDT’ support more challenging (168, New Zealand Society for the Study of Diabetes).

Supervision is necessary but provides challenges in rural communities, six months is considered to be light; twelve months would be more desirable (180, New Zealand Rural General Practice Network).

Five submitters questioned how supervision would be funded (9, 41, 111, 116, 147).

Resourcing to allow on-going education and mentoring and evaluation must be allocated (9, Cancer Nurses Section NZNO).

In the more remote areas there may not be enough supervision for single practise areas, however, by requiring the RN to be working in an MDT we assume there will be no exceptions the funding of Nurse prescribers and GPs to provide supervision to the Nurse Specialist prescribers is of a concern – do you have any solution to this (147, Rural Canterbury Primary Health Organisation)?

Some submitters wanted supervision to be more clearly defined (51, 74, 147, 179, 196) or to be defined by a specified number of cases (57, 122, 129). Seven submitters wanted supervision to be defined by hours, not months (26, 38, 73, 96, 98, 139, 179).

Collaboration on a % of cases, reducing as the RN prescriber becomes more experienced; the wording needs to refer to prescribing practice as currently it could be interpreted more widely to encompass their practice as a whole (57, District Health Board).

Clarity is required in regard to what supervision means in practice hours and how this will occur for those nurses working remotely. A robust quality assurance programme is also required (98, NZNO (Diabetes Nurse Specialist Section)).

Four submitters thought the length of supervision should be defined by the multidisciplinary team (133, 142, 146, 169).

However, six months may be too prescriptive and it may be more useful to say when the nurse is deemed competent by the multidisciplinary team (133, Individual Nurse).

Four submitters suggested the nurses could instead have case review or peer review if supervision was difficult to achieve (13, 39, 164, 184).
Practicing under supervision may limit the number of nurse prescribers due to difficulty achieving this. Others ways of showing competence with prescribing may reduce this barrier e.g. monthly prescribing audits/case studies (184, Individual Nurse Practitioner).

One submitter mentioned the role of the employer (111) and another suggested that nurse practitioners should be able to supervise (57).

…We consider there is a need to be clear about the employer’s responsibility in relation to holding a list of non medical prescribers and ensuring there is a professional focus, with ongoing audit of practice. Probably should report into the Pharmacy and Therapeutics Committee (111, Waitemata District Health Board).
6.5 Scope of practice for specialist nurse prescribing (Question 2.6)

The Council proposed two options to regulate specialist nurse prescribing using the scopes of practice provisions under the Act. The first was to introduce a new scope of practice – specialist nurse prescriber. The second option was for specialist nurse prescribing to be included as an authorisation\(^{26}\) in a registered nurse’s scope of practice. The Council proposed that 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, while the second option may reduce expectations of increased remuneration and would be more acceptable to nursing organisations.

Sixty-five submitters (38%) supported the registration of nurses in a new scope of practice. Most submitters 106 (62%) agreed with an authorisation/condition being included in the registered nurse scope of practice with specialist nurse prescribing authority (see Chart 8 below).

![Chart 8: Scope of practice or authorisation/condition](chart.png)

The following table shows there was almost equal support from individual nurses for both proposals but an authorisation/condition was more favoured by professional organisations (11 nursing) and employers.

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\(^{26}\) Under section 22 of the Act, the Council may change a scope of practice and state the health services a nurse is able to perform.
Table 3: Support for scope or authorisation/condition by submitter type$^{27}$.

<table>
<thead>
<tr>
<th>Sector submission represents</th>
<th>Support a) registered in a new scope of practice</th>
<th>Support b) have an authorisation/condition included in the RN scope of practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual nurses</td>
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<td>21</td>
</tr>
<tr>
<td>Individual nurse practitioners</td>
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<td>4</td>
</tr>
<tr>
<td>Groups of nurses</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>Professional organisations</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>Individual doctors</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>District Health Boards</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Education providers</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Individual pharmacists</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Consumer groups</td>
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<td>1</td>
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<tr>
<td>Aged care provider</td>
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<td>Primary Health (other)</td>
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<tr>
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<tr>
<td>Government agency</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

### 6.5.1 Support for a new scope of practice

Those submitters who supported a new scope of practice gave reasons such as recognition for increased accountability, alignment with other prescribers, greater clarity for patient safety or to meet legal requirements. Five submitters supported a new scope because registered nurses’ roles are already demanding or to recognise the increased accountability of prescribing (39, 46, 66, 77, 106).

$^{27}$ Please note some submitters chose not to provide an answer to this question or provided multiple answers.
Specialist nurse prescribers will have an increased responsibility and personal risk and should therefore be registered in a specialist nurse prescriber scope (77, Group of Nurses, DHB).

A change to the scope of practice more clearly reflects the advanced practice of the registered nurse and the extra responsibility of that nurse. This includes being able to order laboratory tests for diagnosis of conditions within their scope of practice. The ability for nurses to order laboratory testing in tandem with nurse prescribing is necessary in order to achieve the goals of improved and more timely access to care (106, New Zealand Sexual Health Society (NZSHS)).

Two other submitters thought a new scope for specialist nurse prescribing would allow alignment with other prescribers (86, 146).

Option a) registered in a new scope of practice aligns with another group of non-medical prescribers, i.e. pharmacists (86, CAPA - Clinical Advisory Pharmacists Association).

Other submitters thought a new scope would provide clarity for all and therefore be better for patient safety (20, 78, 104, 111, 152, 173, 178).

A new, separate, scope of practice should be introduced for Specialist Nurse Prescribers as proposed in “Option 1” on page 34 of your paper. The Council’s view is that this would provide better protection of public safety because, 1) it provides greater specificity about the role of the Specialist Nurse Prescriber, and in particular emphasises the importance of collaboration in that particular role, and 2) it will provide clarity to patients and other practitioners about which nurses are permitted to prescribe and which are not (152, Medical Council of New Zealand).

Supporting the new scope of practice allows for clarity regarding the role, legality and position of the specialist nurse prescriber (78, Matua Raki - National Addiction Workforce Development).

A new scope of practice for SNPs will emphasise to all—the nurse, clients, other members of the MDT the significance of this nurse being able to prescribe (104, Unitec Institute of Technology).
The Pharmacy Council commented that a new scope of practice was a legal requirement as authorisation/conditions can only be used to restrict activities under the Act.

The Council supports a new scope being developed for specialist nurse prescribers since an RA cannot authorise conditions on a scope of practice. An RA can authorise a scope of practice or authorise a changed scope of practice (HPCAA s21). The changes to the scope of practice may include placing conditions (s22), but these are always restrictive. Before setting a scope of practice, the RA has consulted with all relevant stakeholders. The feedback received will include stakeholders’ risk assessment of the practitioner undertaking all roles described in the full scope. Being allowed to add further roles would circumvent this mechanism. The Pharmacy Council recommends the Nursing Council consult on a new or amended scope, although the former is probably preferable, as conditions would need to be put on the scope of those nurses who cannot prescribe (85, Pharmacy Council of New Zealand).

6.5.2 Support for authorisation

The reasons submitters gave for favouring an authorisation/condition rather than a new scope of practice were that the registered nurse scope is already broad, that a new scope of practice for prescribers would cause issues related to relative remuneration and status, that an authorisation/condition provides more flexibility into the future and a new scope of practice would create confusion with the nurse practitioner scope of practice.

Five submitters commented on their support for authorisation (33, 74, 90, 147, 163).

Conditions are better than additional scopes, as the scope of RN is broad enough, but it is important to be specific about certain extended functions of high importance. Using the addition of a condition would address this in my opinion. This also dovetails with the ECP [Emergency Contraceptive Pill] as an additional condition (33, Individual Nurse).

If a nurse moves job their status may need to change so perhaps replacement of his/her APC [annual practising certificate] with conditions changed could be a more effective means of reflecting their status change than changing scope (74, Group of Nurses).

Thirteen submitters commented on why they did not support a new scope of practice (55, 73, 98, 122, 130, 131, 132, 138, 149, 158, 179, 182, 187).

Definite ‘no’ to another scope, this will incur significant and potentially divisive risks regarding remuneration and status (122, District Health Board).
Some submitters indicated that authorisation was a way to future proof (59, 73, 80).

### 6.5.3 Other comments

Other comments included that the new scope will be too confusing with nurse practitioner (32, 35).

> If given a new scope of practice it becomes confusing for the public and other health professional i.e. how is this the same as or different to Nurse Practitioner scope of practice, with Prescribing (35, Group of Nurses).

Different views were expressed on whether nurse prescribers should receive increased remuneration with several submitters supporting this (3, 12, 13, 20, 21, 27, 39, 41, 48, 110, 144, 164, 175).

> As a senior registered nurse in the Emergency Department I feel that nurses who apply for specialist nurse prescribing authority should have an expectation of increased remuneration. We as nurses need to provide evidence of on-going education and rarely receive remuneration for our accomplishments and achievements, I feel that by applying for prescribing authority indicates a dedication to expertise and increased accountability and I feel that this nurse should be rewarded by increased remuneration (20, Individual Nurse)

> Although we have chosen authority over scope we feel that prescribers should be aligned to the MECA and expect to be recognised for extended practice regardless of scope or authorisation (27, Health Care Development).

Other submitters stated that there should be no link with remuneration (35, 76, 78).

> Remuneration should be based on qualifications and experience /across the board of nursing scale influences rather than simply on prescribing per se. There are a range of specialist skills (e.g. addictions) prescribing should be seen as just one of them. (78, Matua Raki- National Addiction Workforce Development).

> Remuneration should not be linked to prescribing only as this could have the effect of encouraging an uptake of prescribing skills and reliance on prescribing rather than other approaches e.g. nurses with advanced skills in talking therapies such as CBT (35, Group of Nurses).
6.6 Wording of the specialist nurse prescriber scope of practice (Question 2.7)

The Council proposed wording for a scope of practice for specialist nurse prescribers. Most submitters (64.9%) agreed with the wording of the scope statement proposed if nurses with specialist nurse prescribing authority were to be registered in a separate scope of practice.

There were few comments made by submitters about this question. One submitter (5) suggested changing the wording to “they are expert nurses who”…and another suggested making it more patient centred (173). One submitter suggested adding wording to make it clear that the GP is accountable (150).

I would add the doctor is supervising the specialist nurse and the GP will ultimately be responsible for the well being of the patient (150, Compass Health).
6.7 Additional wording in the registered nurse scope of practice (Question 2.8)

Most submitters (76.8%) agreed with the proposed wording (below) to be added to the registered nurse scope of practice if specialist nurse prescribing authority is indicated by an authorisation/condition.

(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.)

A number of submitters suggested minor wording changes. Several submitters wanted to see “some” nurses removed or replaced (27, 43, 50, 76, 118, 120, 122, 130, 131, 132, 149, 182, 184, 187) by “those” (27, 50), “identified” (43), “certain” (117) or “registered” nurses (74). Others suggested replacing “some medicines” with “a limited range of medicines” (35, 184) or “specific medicines” (43, 44, 74). “Additional experience, education” was suggested to be changed to additional “approved” or “advanced” (41), “specified” (5), “higher level” (195), “competency based” (148) or “relevant” (122, 130, 132, 149, 182, 187) education and “highly experienced” (195) nurses. Two submitters wanted the wording to reflect the specific experience and qualifications, e.g. a postgraduate diploma for specialist nurse prescribers (128, 181).

As mentioned above, PHARMAC does not necessarily have any expertise on how scopes of practice should (or are generally) worded. However, it appears to us that the suggested wording could be more specific. With respect to specialist nurse prescribers, this could include reference the specialist experience they are required to have, and the training programme they are required to complete (181, PHARMAC).

One submitter wanted the word training removed (39).

The wording should read experience and education. Training infers an apprenticeship with onsite learning of tasks. Education more appropriately infers the comprehensive knowledge base (informed by research evidence and reflective practice) that underpins application of pharmacotherapeutics to prescribing practice (39, AUT, Faculty of Health & Environmental Sciences).

Others wanted works in a “specialised area” (41) or “prescribes in their clinical area” (148) “in a collaborative relationship” (173) “within a multidisciplinary team” (41) or “collaborative environment” (60) added to the wording.

(Some nurses working in a specialised area and within a multidisciplinary team with additional experience....) (41, Primary Health Organisation)
Three submitters observed that this was the same wording as for community nurse prescribing and questioned whether there should be different wording for specialist nurse prescribing added to the scope statement (65, 153, 181).

A group of Nurse Practitioners (125) suggested adding a phrase from the proposed new scope of practice to the registered nurse scope of practice.

We propose the end of the RN scope statement on P.35 should be added to by incorporating some of the wording from the Specialist Nurse Prescribing Scope of Practice on p.34 in particular ‘They are Registered Nurses with additional experience, education, and training that enables them to assess, diagnose, manage and monitor patients and prescribe safely and effectively within their prescribing authority and area of practice’ (125, Group of Nurse Practitioners).
6.8 Qualification and training for specialist nurse prescribing (Question 2.9)

The Council proposed that specialist nurse prescribers complete a postgraduate diploma in specialist nurse prescribing. The programme proposed includes 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 Council proposed standards for specialist nurse prescriber programmes and competencies that must be satisfactorily assessed by the medical mentor before the nurse is authorised to prescribe.

There was strong support from submitters for the proposed programme, standards and competencies.

Chart 9: Qualification and training, standards and competencies for specialist nurse prescribing

A strong majority of submitters (90.5%) agreed 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.

I agree the proposed education and training is sufficient for prescribing medications. The standards for accreditation are clear and the competencies are accurate and well designed to support a designated speciality nurse prescriber to confidently work with patient safety in mind (21, Individual Nurse).
This is an advanced practice role. Support qualification to undertake this role is postgraduate diploma. RN prescriber could also be mentored by an experienced Nurse Practitioner or medical officer (51, Individual Nurse).

One submitter suggested the qualification be focused to specifically develop nurses in primary health care (67).

Practice nurses for example (although included as PHC nurses) serve a different purpose as they are not working in the community but will be majorly involved in chronic condition management (the majority do not have qualifications for primary health care or practice nursing other than a registered nurse scope without specialty). If funding is available for specialist nurse prescribing it could be attached to a post graduate diploma for primary health care nursing (practice nursing / public health/ diabetes nurse) as a requirement for specialty prescribing (67, Training and Development Services (TADS) Behavioural Change Training).

A small number of submitters disagreed with the level of education suggesting it was inadequate and required more pharmacology (62, 173, 178), it didn’t equate with pharmacist prescriber (86) or should be at master’s level (29).

CAPA is supportive of our nursing colleagues to extend their roles for the benefit of patients. However, as pharmacists with extensive knowledge of medicines, we are acutely aware of the potential for medication error and harm from medications. We have experienced on a daily basis the problems arising from prescribing and therefore understand the complexities and risks involved.

Having a robust training and education framework is one good way to minimise risk, and aligning the postgraduate education requirements with other non-medical prescribing courses is important for the public and other health professionals to have confidence in the process. The postgraduate requirement for pharmacist prescribers is 3 years (2 years pharmacology and therapeutics, 1 year prescribing theory and practicum), and this is on a background of strong pharmacology knowledge from the extensive content in the undergraduate qualification. We have concerns that the proposed 2 year postgraduate requirements for nurse prescribing does not provide for adequate pharmacology and therapeutics teaching.

There is a real need to understand the complex mechanism of action and pharmacokinetics of a medicine to be able to work from first principles to individualise medicines therapy and anticipate ADRs and interactions with other medicines. Information moves forward at such a rapid rate that reliance on textbooks, guidelines and datasheets is inadequate. A depth of understanding of pharmacotherapy based on solid foundation knowledge is essential (86, CAPA - Clinical Advisory Pharmacists Association).
The proposed ‘education/training’ is grossly and dangerously inadequate for safe prescribing. It also fails to take into account the fact that correct assessment and diagnosis informs all types of medical treatment via prescribing. The current proposal would generate negligently incompetent nurse prescribers. To be able to safely prescribe nurses must undertake relevant education equivalent to that of doctors. Currently medical Trainee Interns are not recognised as safe to prescribe, therefore anything less than a level of education equivalent to that of a first year house officer should be considered inadequate. Additionally nurses should have to undertake extra training in clinical assessment and diagnostics, as significant medication harm often occurs as a result of errors of diagnostic assessment (62, Individual Doctor).
6.9 Standards and competencies for specialist nurse prescribing (Questions 2.10 and 2.11)

Most submitters agreed with the proposed standards for programmes (92.2%) and competencies (94.6%) for specialist nurse prescribing.

Both practice standards and competencies are clear, measurable and summative assessment points for competence at specialist level of practice (148, Government Agency).

The Pharmacy Council supports the use of an adaptation of the Australian National Prescribing Service (NPS) prescribing competencies. The Council agrees that generic prescribing competencies should be developed to deliver a national standard of prescribing for all non-medical prescribers and that a single competency framework can capture the core competencies prescribers need to do this safely and effectively. These are therefore, the same competencies that community nurse prescribers should practise to (85, Pharmacy Council of New Zealand).

6.9.1 Recognition of qualifications

Many submitters (9, 12, 13, 16, 17, 25, 42, 48, 49, 64, 91, 93, 99, 103, 110, 123, 140, 145, 164, 167, 192) were concerned that there needs to be a pathway for nurses who have already gained a master’s degree, or completed similar papers, not needing to meet the requirements or being able to RPL (recognition of prior learning) into such a programme. A few mentioned a pathway for diabetes nurse prescribers (13, 98, 187).

The competencies/education needs to be better described for nurses who have previously completed post-graduate studies (i.e., not a specific post graduate diploma in specialist nurse prescribing). For example, a nurse may have a Masters in Nursing, including a non-prescribing practicum. What, if any, bridging papers will need to be done? Is the ‘prescribing praxis’ a post-graduate paper, or time spent with, and supervision by, a prescribing mentor? Is the level of education recommended consistent with that which the diabetes nurse prescribers are currently required to do? If not, how will this difference be bridged? (13, Group of Nurses, DHB CNS).

6.9.2 Broaden mentor to include nurse practitioner

In terms of the content of the programme six submitters suggested that the designated medical mentor requirement be changed to authorised prescriber or health professional mentor (51) to include nurse practitioners when they become authorised prescribers (39, 98, 124, 137, 179, 187).
Throughout the consultation documentation there is reference to “designated medical prescriber” and “medical supervisor”. We emphasise that this term needs to be “Authorised prescriber” and “designated supervisor” to a) remove the medical model language from a nursing document and b) enable Nurse Practitioners to become designated authorised prescribers and supervisors. We are aware that there are fewer Nurse Practitioners who could take these roles and that those within medicine will need to be supervisors. We do not believe that only doctors can be supervisors. The nursing profession ‘models of care’ need to be very clear in this nursing council document (39, AUT, Faculty of Health & Environmental Sciences).

6.9.3 Include mental health conditions

Four submitters (35, 76, 78, 158) suggested that the programme include common mental health conditions such as anxiety, substance abuse, depression, bipolar disorder and schizophrenia.

Pg. 57 Learning outcomes – Common conditions. Ensure the conditions included as examples are relevant to nurses working in Mental health and Addiction e.g. Substance use disorders, Depression, anxiety, bipolar affective disorder etc. Too often common conditions for mental health and addiction nurses are not included when courses are developed (35, Group of Nurses).

6.9.4 Other comments

Seven submitters stated that they agreed this programme should become a prerequisite for nurse practitioner programmes (122, 130, 131, 132, 149, 182, 187).

Other comments related to ensuring the “clinical base of the programme” (26, 179, 187). It should include a pharmacist (125), include a specialist paper (125), include appraisal of research and evidence (165), there are too many practicum hours (60, 121), the mentor will be a barrier (124, 129), there are difficulties for rural nurses (180), clinical release for supervision is impractical (1), it should add cultural competencies, clinical supervision and case reviews (44), the course lacked nursing philosophy and frameworks (39), and how will it be funded (73)?

One submitter suggested changing the title of the programme as prescribing will only one element of the nurse’s role so the title should reflect this for example, Postgraduate Diploma in Nursing and Prescribing or Postgraduate Diploma in Nursing (Prescribing) (92).
6.10 Entry criteria for specialist nurse prescribing programmes (Question 2.12)

The Council proposed 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/his employer to undertake the postgraduate diploma in specialist nurse prescribing and must confirm 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 to continuing education.

The majority of submitters (66.2%) agreed with the entry criteria for a specialist nurse prescribing programme.

The criteria have been well constructed to ensure individual, employer and training aspects are drawn together and that appropriate systems and process are in place that support this level of prescribing. Having to show you have support from your employer and have an authorised prescriber mentor will ensure this ‘training’ is restricted to the nurses who will upon successful completion add prescribing to their practice (80, District Health Board and 111, Waitemata District Health Board).

6.10.1 Years of clinical experience

Most submitters who disagreed with the criteria commented on the number of years of practice a nurse had to complete before entering a programme.

Fifteen submitters stated that one year in a specialty area was not long enough (1, 23, 41, 44, 51, 52, 60, 76, 77, 78, 97, 112, 114, 116, 117).

…One year of practice in a specialist area will not be enough if no previous experience in a similar area. Confidence to prescribe in speciality areas comes with working there for a certain length of time (77, Group of Nurses, DHB).
We consider the one-year prerequisite in a current area of practice to be too short. Nurses new to General Practice or working in the community may be to be at a novice level after 12 months. We recommend that the entry criteria be evidenced by nurses undertaking PDRP within their area of practice at a proficient level. Nurses who move from one area to another, but remain in their speciality of practice (for example nurses working within cardiology in a hospital but then work within primary care (e.g. a primary care network) and continue to work within this speciality needs further consideration (116, Non-Government Organisation).

Thirteen submitters supported two years of experience (21, 26, 27, 44, 63, 65, 81, 122, 153, 161, 164, 172, 175), five submitters two to three years’ experience (98, 111, 129, 179, 187), 12 submitters at least three years' experience (24, 35, 38, 43, 91, 96, 110, 123, 125, 147, 158, 165), four submitters three to five years’ experience (31, 46, 96, 164) and 11 submitters five years’ experience (13, 28, 34, 54, 82, 86, 91, 123, 166, 171, 190).

It takes at least 2 years working in the area of sexual health to become experienced; 1 year is not long enough (81, Individual Nurse).

No. Three years post registration full time practice with at least one year in the area of practice is not long enough to gain expertise. The intention for prescribing medicines for common conditions in general practice examples given asthma, diabetes, hypertension do not necessarily reflect a typical patient profile. Patients who are hypertensive may well have elevated cholesterol, diabetes, degree of heart failure. As with diabetes their hypertension is very likely to alter for various reasons and/or temporary metabolic changes. The prescribing nurse should possess a very sound advanced knowledge of these co-morbidities and the various manifestations of presentations of such patients. It is not possible for this wider reference to base practice decisions on to develop in 3 years. In addition the RN should possess advanced knowledge of healthcare delivery as this patient may well move across the continuum of care e.g. primary to tertiary and back (96, MidCentral/Wanganui DHB Regions Primary Health Care Nurse Practitioners and Interns Peer Review Group).

I think that 3 years practice as a RN is too short a time frame. 5 years FTE would mean this nurse is at a senior nurse level and would also provide the needed time to gain the qualification required for prescribing. 1 year within the specialty would then be appropriate (28, Individual Nurse).

Six submitters commented that one year in a specialty would be adequate if it was full-time or minimum hours (130, 131, 132, 149, 182, 187).

Entry criteria- the ‘one year’ in area of practice should either specify full year or minimum hours (130, Hawke's Bay District Health Board).
6.10.2 Lack of employer support

Other submitters commented on the lack of employer support or variable support (64), and that “GPs will not fund” (42). A lack of support in primary care was identified (36, 125, 180), with incentives needed for reluctant employers (88). A lack of funding was an issue (10, 48).

It is imperative that the employment / funding model / pay scales are in place ahead of the RNs commencing the prescribing requirements. This has been a major barrier for progression of the NP role particularly in primary care settings (125, Group of Nurse Practitioners).

The NZCPHCN support the notion of RN prescribing but urge the Nursing Council to acknowledge and plan for the uniqueness of the community work environments where many nurses work in isolation- e.g. rural nurses, public health nurses and in many situations have no other peers, to prevent isolation and unsafe practice. These nurses will require a robust means of training, supervision and ongoing support and not just have to be relied on to forge these themselves, as Nurse Practitioners in PHC have had to do in many cases. We suggest that the [Council] look to the current GP registrar training programme as a training and education system that well supports new practitioners in the PHC environments.

We are also concerned at the potential marginalisation of nurse practitioner roles in community and ask that the initiation of RN prescribing is marketed carefully to reduce the risk of employers seeing the new role as the “cheap” option.

We recognise that the RN prescribing role will assist nurses whose skill base and work environment enable them to utilise this role for the benefit of patients, and congratulate the Nursing Council for their work on this (36, NZ College of Primary Health Care Nurses, NZNO).

6.10.3 Other comments

Eight submitters suggested linking entry criteria to proficient or expert level on PDRP (41, 43, 50, 116, 156, 158, 159, 167) or to provide evidence of advanced practice (74).

A few submitters disagreed with the criteria stating they were “too controlling” (55), and the nurse had the right to choose to undertake the programme regardless of employer support (20). Another commented that criteria should be developed with educators (55). Two submitters stated that the entry criteria should be a postgraduate certificate (47) or a postgraduate diploma (174).

One submitter commented that education frameworks make the practicum more robust (148).
6.11 Continuing competence and monitoring (Question 2.13)

The Council proposed 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 proposed that it monitors these requirements are met every three years.

A strong majority of submitters (81.3%) agreed with the continuing competence requirements for specialist nurse prescribers.

Totally agree. Robust monitoring, peer review, reporting systems and 3 yearly competence assessments are critical (125, Group of Nurse Practitioners).

The Directors of Nursing group supported these requirements (158, Canterbury Regional Directors of Nursing and Canterbury Postgraduate Nursing Education).

Some submitters particularly supported audit and peer review (32, 42, 147, 150, 173, 189, 190).

Audit and peer review will be essential (147, Rural Canterbury Primary Health Organisation).

6.11.1 Sixty days of prescribing practice

Many questioned how the 60 days of prescribing practice would be measured (27, 34, 59, 64, 71, 75, 97, 99, 111, 140, 150, 164).

How will the 60 hours of prescribing practice be evidenced to the Nursing Council (64, Individual Nurse)?

Number of scripts vs. 60 days of prescribing practice? Will there be random audits (71, Group of Nurses, Primary Health)?

Nurses need to be able to demonstrate in their practice their ability to prescribe/re-prescribe every day, not every 3 years and not stated as 60 days of prescribing practice. Prescribing should be considered a skill that occurs in our everyday practice. This should be easily demonstrated by the nurse that is competent in practice (147, Rural Canterbury Primary Health Organisation).

A few submitters thought 60 days was too short and suggested 100 days (13, 174, 176) or 120 days (36, 51).
However sixty hours of prescribing in the last 3 years may not be sufficient to maintain competency and we would ask NC to consider 120 hours (36, NZ College of Primary Health Care Nurses, NZNO).

### 6.11.2 Professional development hours

Submitters who commented on professional development wanted it defined (43, 52, 91, 153, 178).

> How many of the 60 professional development hours are expected to be spent on prescribing as we feel this is a little vague (91, Group of Nurses).

> Further guidelines are required regarding the breakdown of the 60 hours of professional development demonstrating the on-going mentorship. There needs to be appropriate documentation representing this process to ensure all competencies are met and fulfilled. This process must have on-going support by employers (153, Nurse Maude Association).

A few submitters wanted professional development to be mandated by the Council (9, 140, 175, 179), or to be included in the MECA\(^{28}\) (13, 77, 98).

> In theory the requirements are satisfactory, but there must be support and access to education and professional development mandated at Nursing Council level so that it can be included within the industrial employment agreement (9, Cancer Nurses Section NZNO).

> **BUT** clarification is required about “60 days of prescribing” as mentioned before and protected study days to ensure employers release nurses for updates (175, Individual Nurse).

Three submitters said the Council did not need to specify professional development hours (110, 129, 192).

> Our nurses already have onerous requirements. I would suggest that this should be incorporated into existing arrangements, especially as NCNZ will hold the data of who is involved. (129, Individual Doctor).

Two submitters thought the professional development hours were too short (13, 164).

> The 60 hours of professional development in three years is also too low. 20 hours a year is barely sufficient for an RN without prescribing but for a prescriber who needs to do audits,

\(^{28}\) Multi Employer Collective Agreement.
regular case reviews, and stay up-to-date with the medications and conditions they are prescribing 40 hours per year would be an acceptable minimum. Again, these extra professional development hours need to be protected under the MECA (164, Group of Nurses, DHB).

Others were concerned about who would provide the professional development and if it would be in an online format (28, 99, 145).

I am unsure on what professional development on prescribing is available to complete each year – is their accessible education planned or in place? (145, Individual Nurse).

I support ongoing competence for practicing certificate. Completing a number of hours of professional development in prescribing every 3 years may mean courses need to be opened up either at an organisational level, through training institutions or on-line (28, Individual Nurse).

6.11.3 Case review with a mentor

Some submitters wanted more definition of a suitable mentor (32, 43, 77, 128) and others thought the mentor could be a nurse practitioner (57, 130, 131, 132, 149, 182, 187). One suggested the mentor be accredited by the College (150).

6.11.4 Three-yearly monitoring by the Council

Eleven submitters thought there should be annual competency (57, 130, 131, 132, 149, 172, 182, 187) with a small number suggesting this should form part of the annual renewal of practising certificates (62, 63, 147).

- Need to find suitable and good quality supervision and mentorship. Need to have some protected time for peer/case review. Suggest this is part of annual competency requirements.
- NPs will be good here as supervisor with Medicines Act change (132, Health Hawke's Bay (Public Health Organisation)).

Prescribing certificates should be renewed every year as for other medical professionals. Nurses must complete remedial education if they are not prescribing for a period of time greater than 3 months in one year in addition to normal continuing education requirements (62, Individual Doctor).

One submitter suggested monitoring every 18 months (32) and another suggested two yearly (170). One stated that the Council should also check the nurse is working in the area they are authorised for prescribing (104).
6.11.5 Other requirements

A few submitters mentioned a requirement to submit a portfolio (123, 148, 167) or link to a PDRP (50, 96, 138), and a few suggested the employer should have a role in monitoring (5, 147, 153). A few submitters commented on how a nurse might regain prescribing authority if lost (20, 21, 62, 137, 138).

Question asked about what would happen if nurse is unable to maintain prescribing competence especially if due to illness, remote rural practice etc. (138, District Health Board).

One submitter pointed out that rural nurses might need special requirements (180).

RN needs to be able to demonstrate on-going endorsement by employer, particularly because they are required throughout the paper, to work in a multi-disciplinary team Should be separately endorsed and not through PDRP (180, New Zealand Rural General Practice Network).
6.12 Proposed list of prescription medicines for specialist nurse prescribing (Question 2.14)

A majority of submitters (62.3%) agreed that the indicative community nurse prescribing and specialist nurse prescribing lists of prescription medicines reflected the range of medicines that nurses with specialist nurse prescribing rights will need to access.

What is really refreshing is to see a list of medications which is comprehensive but adaptable according to scope of practice and individual skills. Are the lists sufficient—sorry I don’t have time to give this justice. As far as I can see, the list is pretty comprehensive. My advice would be to keep the list as a schedule under annual review. It can be tested against need in use and refined as required (61, Individual Doctor).

In relation to my role the list for specialist nurses including the community nurse list looks appropriate (28, Individual Nurse).

Some submitters were concerned that the list was too extensive (22, 23, 27, 31, 41, 79, 99, 115, 116, 129, 147, 150, 170, 174, 176, 194, 196) and should be restricted or formulated according to area of practice (7, 20, 47, 92, 96, 125, 173, 161) or according to specialty lists (20, 21, 38, 52, 75, 111, 128, 129, 140, 144, 150).
A wider range of drugs suitable for repeat prescribing (with some requirement for occasional authorised prescriber review) would be a better way to go. This is far too many across far too many fields. They need to be grouped therapeutically and candidates should need to specify/sign up to competence in one or more therapeutic groups - our diabetes nurses would not be expert in COPD for example. Including OTC medicines would be entirely appropriate if funding/access issues can be overcome (129, Individual Doctor).

Both nurses and pharmacist in our organization believe the list is too extensive. While a nurse working in a specific area may well be “qualified” to prescribe in that area (e.g. mental health). The availability of the list assumes that all who have done the training also have the experience in that area which may not be so (170, Health Reporoa).

I agree with the list of prescribed medications but should be limited to the speciality the nurse has in their defined scope of practice, similar to nurse practitioner. Why would a nurse practitioner have a defined scope of practice and only be able to prescribe around that defined area, compared to the speciality nurse who is able to prescribe across many different specialities and disease processes? The ultimate responsibility for prescribing a medication to a patient group is with the person who writes the prescription, even if they are in collaboration with a general practitioner (21, Individual Nurse).

Many submitters suggested repeat prescribing might be more appropriate for some medicines (3, 12, 39, 41, 46, 97, 114, 128, 129, 143, 165, 170, 171). The feedback related to repeat prescribing can be found under section 6.14. Three submitters suggested that the route of administration be included (73, 114, 187). Some submitters thought some items should not be on the list at all (85). This is further developed in the next section.

Council is concerned about the inclusion of some medicines that we believe should only be initiated or repeat prescribed by a medical practitioner. GPs do not initiate some of these medicines so it is of concern to see them included here (85, Pharmacy Council of New Zealand).

Other submitters commented that the lists should be reviewed (137, 164, 184) by specialist groups (42, 59, 114, 159, 164) or by nurse practitioners (55).

Some submitters suggested that medicines be added to the list.

We are concerned about the absence of long-acting anticholinergics (tiotropium). We presume that combination inhalers (Seretide, Vannair and Symbicort) can be prescribed as the products in the combination inhalers are listed separately. We also presume that specialist nurse prescribers will be able to apply for Special Authority numbers for these medications (13, Group of Nurses, DHB CNS).
For the specialty of cancer nursing antiemetics, laxatives, 5HT3 antagonists and proton pump inhibitors and antidiarrhoeals. Mild analgesia, such as paracetamol. Medicines such as Nilstat for oral candidiasis (9, Cancer Nurses Section NZNO).

As a very experienced community mental health nurse I am concerned about the reservations mentioned in the consultation document that specialist nurse prescribers may not be able to provide initial prescriptions of anti-psychotics. I am also concerned at the random selection of anti-psychotics included in the list. Some hardly used typical anti-psychotics are listed where as frequently used, almost first line treatments, such as Risperidone is not included. Risperidone tablets do not need special authority (although the oral dispersible wafers and Consta IMI does). Should most medications commonly used be included (if no special authority is required) (64, Individual Nurse)?

Omissions for commonly used psychiatric meds include risperidone, quetiapine, aripiprazole, lithium, sodium valproate (154, Individual Nurse).

Ophthalmology is a small area of practice for nursing in New Zealand but there are many nurses within the speciality who meet the criteria outlined for the specialist nurse prescriber (133, Individual Nurse and 142, Individual Nurse).

A summary of the suggested additions to the list can be found in Table 4 which follows.
<table>
<thead>
<tr>
<th>Medicine suggested to be added to the list</th>
<th>Submitters</th>
</tr>
</thead>
<tbody>
<tr>
<td>tiotropium</td>
<td>13, 165</td>
</tr>
<tr>
<td>erythropoietin</td>
<td>54</td>
</tr>
<tr>
<td>escitalopram</td>
<td>61</td>
</tr>
<tr>
<td>risperidone</td>
<td>64, 76, 154</td>
</tr>
<tr>
<td>olanzapine</td>
<td>76</td>
</tr>
<tr>
<td>quetipine, aripiprazole, lithium, sodium valproate</td>
<td>154</td>
</tr>
<tr>
<td>vaccines</td>
<td>58, 141, 116</td>
</tr>
<tr>
<td>immunoglobulins</td>
<td>58</td>
</tr>
<tr>
<td>ophthalmology medicines</td>
<td>113, 133, 142, 146, 160, 162, 169</td>
</tr>
<tr>
<td>ethanol 70%, urokinase, altephanse, citrate</td>
<td>95</td>
</tr>
<tr>
<td>dressings</td>
<td>167</td>
</tr>
<tr>
<td>mifegyne, misoprostol</td>
<td>172</td>
</tr>
<tr>
<td>metolazone, slow k, chloravesant, Span K</td>
<td>175</td>
</tr>
<tr>
<td>corticosteroids, methotrexate</td>
<td>177</td>
</tr>
<tr>
<td>medicines and blood products used in neonatal units</td>
<td>192</td>
</tr>
<tr>
<td>steroid creams</td>
<td>144</td>
</tr>
<tr>
<td>palliative care</td>
<td>9, 124, 140, 153</td>
</tr>
<tr>
<td>non-prescription items</td>
<td>147</td>
</tr>
<tr>
<td>cefoxitin, compound sodium lactate, gelofusine, paracetamol/codeine, penicillin</td>
<td>92</td>
</tr>
<tr>
<td>otology meds</td>
<td>162</td>
</tr>
</tbody>
</table>
6.13 Prescription medicines nurses should not be able to access (Question 2.15)

Submitters were also asked if there were prescription medicines included on the lists that specialist nurse prescribers should not be able to access. Thirty-nine submitters (26.5%) wanted medicines removed (see Chart 10).

Some submitters wanted medicines removed from the lists as they were considered too dangerous. They included several classes of medicines like antipsychotics, antidepressants, immunosuppressants, antiarrhythmic agents, anticoagulants and antibiotics. Several individual medicines were identified as well (see Table 5).

Many of the medicines on the proposed list are associated with potentially serious adverse events, frequent drug interactions, a high risk of dependency and/or toxicity (69, New Zealand Medical Association)

Medicines not considered to be current best practice first-line choices e.g. tricyclic and tetracyclic antidepressants for depression, chlorpromazine for schizophrenia, captopril, buspirone. Medicines where the selection would indicate the medical condition is complicated and/or refractory and should therefore be assessed by a medical practitioner. Many of the IV preparations are inappropriate e.g. aminophylline. Medicines requiring Special Authority (86, CAPA - Clinical Advisory Pharmacists Association).
Table 5: Individual medicines some submitters wanted removed from the specialist nurse prescription medicines list

<table>
<thead>
<tr>
<th>Prescription medicine</th>
<th>Classification</th>
<th>Submission made that medicine be removed from the list</th>
</tr>
</thead>
<tbody>
<tr>
<td>captopril</td>
<td>ACE inhibitor</td>
<td>86</td>
</tr>
<tr>
<td>sulfasalazine</td>
<td>aminosalicylate</td>
<td>187, 188</td>
</tr>
<tr>
<td>procyclidine</td>
<td>antiemetic</td>
<td>86</td>
</tr>
<tr>
<td>trimeprazine</td>
<td>antihistamine</td>
<td>86</td>
</tr>
<tr>
<td>midodrine</td>
<td>antihypertensive</td>
<td>86, 115, 176</td>
</tr>
<tr>
<td>clopidogrel</td>
<td>antiplatelet agent</td>
<td>31</td>
</tr>
<tr>
<td>buspirone</td>
<td>anxiolytic</td>
<td>86</td>
</tr>
<tr>
<td>hydroxychloroquine</td>
<td>arthritis agent</td>
<td>86</td>
</tr>
<tr>
<td>colestipol</td>
<td>bile acid sequestrant</td>
<td>86</td>
</tr>
<tr>
<td>colestyramine</td>
<td>bile acid sequestrant</td>
<td>86</td>
</tr>
<tr>
<td>aminophylline</td>
<td>bronchodilator</td>
<td>86</td>
</tr>
<tr>
<td>isradipine</td>
<td>calcium channel blocker</td>
<td>115, 176</td>
</tr>
<tr>
<td>nifedipine</td>
<td>calcium channel blocker</td>
<td>86</td>
</tr>
<tr>
<td>verapamil</td>
<td>calcium channel blocker</td>
<td>86</td>
</tr>
<tr>
<td>clonidine</td>
<td>centrally acting hypertensive</td>
<td>86, 115, 174, 176</td>
</tr>
<tr>
<td>methyl dopa</td>
<td>centrally acting hypertensive</td>
<td>86</td>
</tr>
<tr>
<td>acarbose</td>
<td>diabetes agent</td>
<td>115, 176</td>
</tr>
<tr>
<td>papaverine</td>
<td>erectile dysfunction</td>
<td>115, 176</td>
</tr>
<tr>
<td>gemfibrozil</td>
<td>fibrate</td>
<td>115, 174, 176</td>
</tr>
<tr>
<td>protamine</td>
<td>heparin antidote</td>
<td>3</td>
</tr>
<tr>
<td>colchicine</td>
<td>hyperuricaemic</td>
<td>129, 150</td>
</tr>
<tr>
<td>glibenclamide</td>
<td>hypoglycaemic agent</td>
<td>86, 111</td>
</tr>
<tr>
<td>glibenclamide</td>
<td>hypoglycaemic agent</td>
<td>86, 111</td>
</tr>
<tr>
<td>azathioprine</td>
<td>immunosuppressant</td>
<td>31, 41, 54, 62, 86, 150, 178, 194</td>
</tr>
<tr>
<td>leflunomide</td>
<td>immunosuppressant</td>
<td>31, 54, 62, 86, 178</td>
</tr>
<tr>
<td>oxytocin</td>
<td>labour induction</td>
<td>85</td>
</tr>
<tr>
<td>dantrolene</td>
<td>muscle relaxant</td>
<td>115, 174, 176</td>
</tr>
<tr>
<td>acipimox</td>
<td>nicotinic acid group</td>
<td>115, 174, 176</td>
</tr>
<tr>
<td>nicotinic acid</td>
<td>nicotinic acid group</td>
<td>115, 176</td>
</tr>
<tr>
<td>chlorthalidone</td>
<td>thiazide-related diuretic</td>
<td>115, 176</td>
</tr>
<tr>
<td>hydralazine</td>
<td>vasodilator antihypertensive</td>
<td>86, 115, 174, 176</td>
</tr>
<tr>
<td>sodium nitroprusside</td>
<td>vasodilator antihypertensive</td>
<td>115, 176, 186</td>
</tr>
</tbody>
</table>
6.14 Prescription medicines specified for repeat prescribing
(Question 2.16)

The Council asked if it is necessary to identify some medicines that specialist nurses may not initiate but could safely repeat prescribe, for example antipsychotic medicines. Most submitters (74.1%) agreed that some medicines might not be initiated but repeat prescribed.

Particular classes of medicines were identified, notably cardiac medicines and medicines requiring close monitoring (77). These included ACE inhibitors, antiarrhythmics, betablockers, antibacterials, anticoagulants, anticonvulsants, antidepressants, antipsychotics and immunosuppressants.

Others were of the view that “If you can repeat prescribe you can prescribe” (33, 36, 38, 61, 139, 161, 163).

I feel that if you are not able to initiate a prescription, you are probably not the right person to be reviewing or repeating it either (61, Individual Doctor).

Mental health medicines were supported for repeat prescribing by nurses and the Royal New Zealand College of Anaesthetists. The prescribing of opioids substitution by nurses is specifically prohibited under the Misuse of Drugs Act (1975) so these medicines were not included in the list proposed by the Council.

We would strongly support the Council considering medicines that specialist nurses could safely repeat prescribe within the specialty services of mental health and addiction. Such medicines should include consideration of antipsychotic medicines, antocraving medications such as naltrexone for alcohol dependence as well as disulfiram for alcohol dependence; medicines for alcohol withdrawal and medicines for opioid substitution treatment particularly buprenorphine (eg. In combination with naloxone) and methadone. We are aware that the barriers to nurse practitioner prescribing for drug dependence inherent in the Misuse of Drugs Act are being addressed following the barriers again being raised (76, Te Ao Māramatanga, NZ College of Mental Health Nurses).

Psychiatry may benefit from highly trained and experienced specialist nurses who could prescribe and monitor some of the long term medications. However, a specialist nurse should not be initiating new prescriptions. A particularly useful contribution of a specialist nurse prescriber would be repeat prescriptions of well-established medications. This could include drugs such as clozapine and methylphenidate that require monthly repeat prescriptions. Drugs such as clozapine would fit well into specialist nurse prescribing of established medications, as nurses have particular expertise around following protocols and generally carry out all required checks and monitoring to a high standard (143, The Royal Australian & New Zealand College of Psychiatrists).

Mental Health is an area where initiation of medicines is fraught and the group would suggest specialist nurse prescribers should not initiate but could repeat prescribe if a patient
is stable. The decision on whether a patient is stable, unless made by a multidisciplinary team, would need to be based on a documented process (148, Government Agency).

One submitter commented that the role of the specialist nurse prescriber is to repeat prescribe or change the dose but not to initiate (62). Another submitter suggested specialist nurse prescribers should set out a practice plan similar to that required for pharmacist prescribers (173) or that the initiation or repeat prescribing should be decided by the specialty or team (75, 97, 140). Others thought it was okay if the nurse was working directly with the medical practitioner (110, 123, 148) or with protocols (128).

Specialist nurse prescribers should be able to access the medicines on the prescription medicine lists but only following diagnosis by a medical practitioner and unless it is within their speciality area under the direction of a medical practitioner. For example; a renal specialist nurse prescriber would not initiate an amiodarone prescription unless directed by a medical practitioner. If amiodarone was not on the prescription medicine list, the specialist nurse prescriber would not be able to prescribe it if a cardiologist rang and directed them to prescribe amiodarone (148, Government Agency).

Two submitters supported the repeat prescribing of specialist-only medication and special authority items.

The College’s view is that there are many medications that are not ever initiated by general practitioners (GPs), but GPs do repeat prescribe on the instruction of a specialist. The same situation should apply to specialist nurse prescribing (56, College of Nurses Aotearoa New Zealand).

With the Diabetes Nurse Prescribers model, we have a Schedule rule that only permits subsidy for a medication requiring a Special Authority if it is for a repeat prescription (i.e. after the initial prescription with Special Authority approval was dispensed). It is possible that we would consider proposing this to PHARMAC’s Board with respect to specialist nurse prescribers as well (181, PHARMAC).
6.15 Non-prescription medicines (Question 2.17)

Nearly all submitters (98.2%) agreed that specialist nurse prescribers should be able to access the list of non-prescription medicines.

\[
\text{Definitely – if able to prescribe oral and injectable hypoglycaemic agents then essential to be able to prescribe the delivery devices i.e. insulin pen needles and lancets and the monitoring devices for these. If a nurse is an independent vaccinator then they should be able to prescribe vaccines. Many of the medications listed are available on the shelf of the pharmacies and don’t need a prescription to purchase so why would a nurse with comprehensive knowledge and experience be restricted from prescribing these (12, Individual Nurse).}
\]

Various submitters commented that some of the non-medicine items listed do not attract a subsidy (85, 86, 128, 178) and that some non-medicine items should also be accessible to community nurse prescribing (124, 147, 158).
6.16 List of controlled drugs for specialist nurse prescribing (Question 2.18)

Designated nurse prescribers (nurse practitioners) are already able to prescribe from a list of 42 controlled drugs outlined in the Misuse of Drugs Regulations 1977. As nurse practitioners will become authorised prescribers under the Medicines Amendment Bill, the Council proposed a new list of 15 controlled drugs for specialist nurse prescribing. Some of the medicines on the nurse practitioner list were considered to be no longer in use or outside the therapeutic areas for specialist nurse prescribing.

Chart 11: Support for list of controlled drugs for specialist nurse prescribing and the ability to prescribe for longer than three day supply.

Most submitters (81.8%) agreed with the proposed list of controlled drugs that nurses with specialist nurse prescribing rights will be able to prescribe as designated prescribers.

Agree with the [Council] proposed list which is much more practical than the Misuse of Drugs Act 1977 list (this lists many inappropriate and discontinued medicines). Suggest reduce number of benzodiazepines available (86, CAPA- Clinical Advisory Pharmacists Association).

If training is adequate, peer review and monitoring systems robust and positioned within their approved clinical scope of practice (125, Group of Nurse Practitioners).

I can see areas where CD prescribing would be appropriate and if you allow one benzodiazepine or opiate, you may as well allow them all. A cautious yes to CD prescribing then but reservations exist – perhaps there should be a specific audit for these medications (61, Individual Doctor).
There will be chronic patients the nurse will be the case manager for and if underpinned by experience and competency then appropriate for this to happen (187, DHB Shared Services).

Other submitters were more cautious in their agreement believing it would depend on the specialty or ‘scope’ of the nurse (25, 38, 47, 52, 96, 125, 140, 179, 187) or to restrict this to specialty areas (128, 129, 140, 147, 158) or have an additional authorisation (93, 143).

Only if the drugs are appropriate to the nurses area of specialist practice. For example many of these drugs would be appropriate if the nurse is an authorised nurse specialist prescriber in palliative care. However it would not be appropriate for a specialist nurse prescriber working in diabetes care to prescribe Morphine (52, Group of Nurses).

- Commencing a medication would have to be related to the context setting e.g. a Nurse Specialist working in a clinical setting that manages a methadone programme could prescribe/re-prescribe methadone not an RN in a GP practise; or morphine is the domain of the Palliative Care Nurse Specialist. Clarity needed around the clinical context
- Controlled drugs should be considered an additional endorsement
- Some of the controlled drugs on the list seldom used these days

This group of drugs might better be placed in a re-prescribing category (147, Rural Canterbury Primary Health Organisation).

There was support for nurses to be able to prescribe controlled drugs in palliative care (20, 53, 98, 111, 128, 129, 140, 147, 164, 171) and for long-term conditions (6). Pain management was also identified as an appropriate specialty (53, 98, 111, 128, 129, 140).

I do not agree that the specialist nurse should have prescribing rights of controlled drugs. If the patient needed controlled drugs their condition should be reviewed by a medical practitioner or a nurse practitioner. However if a palliative specialist nurse has authority to prescribe limited controlled drugs I do not see that as a problem as long as it was written into their scope of practice (20, Individual Nurse).

E.g. Low dose morphine for treatment of end stage COPD and heart failure (6, Individual Doctor).

These drugs are controlled because they are dangerous- to the consumer, the public, and the prescriber. We support the initiation of prescription of these drugs by the specialist Pain Nurses, but only as part of a therapeutic team (186, New Zealand Society of Anaesthetists).

For mental health there was support for prescribing of some drugs including clonazepam (43, 64, 154). The College of Mental Health Nurses supported opioid substitutes (76).
I believe that Clonazepam should be added to the proposed specialist nurse – controlled drug list (pg. 44) as this is regularly used in mental health settings (64, Individual Nurse).

We would strongly support the Council considering medicines that specialist nurses could safely repeat prescribe within the specialty services of mental health and addiction. Such medicines should include consideration of antipsychotic medicines, anticonvulsant medications such as naltrexone for alcohol dependence as well as disulfiram for alcohol dependence; medicines for alcohol withdrawal and medicines for opioid substitution treatment particularly buprenorphine (eg. in combination with naloxone) and methadone. We are aware that the barriers to nurse practitioner prescribing for drug dependence inherent in the Misuse of Drugs Act is being addressed following the barriers again being raised (76, Te Ao Maramatanga, NZ College of Mental Health Nurses)

Some submitters wanted some medicines removed as they did not think they would meet the emergency requirement (115, 174, 176). Two submitters (14, 115) wanted most benzodiazepines removed from the list. Some submitters wanted medications added to the list (e.g. pethidine (92)), some from the old list (91) or further restrictions added (60).

Think the list is too long. Remove Diazepam from the list for all.
For Mental Health Specialist nurse prescribers they should not be able to prescribe the following Alprazolam, Codeine, Dihydrocodeine, Fentanyl, Lorazepam, Methadone, Morphone, Oxycodone (43, Group of Nurses, DHB).

Only in an emergency. I do not believe the following medicines are required in an emergency: Alprazolam, lormetazepam, nitrazepam, oxazepam, temazepam, triazolam, zopiclone (176, Individual Pharmacist).

The Guild supports the current list of 15 controlled drugs, however there would need to be very strict parameters around their use. These should include that they must have been prescribed by a doctor previously, there must be no signs of overuse or abuse, and that they are required in the case of a genuine emergency supply (60, Pharmacy Guild of New Zealand).

One submitter was concerned that the legislation does not presently allow for the list to be reviewed regularly (137).

In principle yes but as above need further robust consideration once the authority question is decided. Any list of medications quickly becomes outdated with the risk of not being dynamic in terms of changing best practice guidelines. We recommend that any list be reviewed and updated regularly by appropriately qualified health professionals. We need a legislated mechanism for updating the list annually and adhoc as research may indicate potential patient harm as new evidence that emerges, in addition to those medicines which lose the restriction of specialist only (137, Nurse Practitioner New Zealand (NPNZ)).
A minority of submitters disagreed with the proposal with seven submitters stating prescribing of controlled drugs should be up to a doctor or a nurse practitioner (20, 21, 54, 97) or doctors only (23, 62, 150). Others said it was too inclusive of opiates and benzodiazepines (31, 74, 86) and one submitter commented that oxycodone should be for doctors only (85). Others were concerned about benzodiazepines and nurses being exposed to drug seekers (39, 114, 140) or misprescribing (85).

No, better leave the decision to the GP or specialist (150, Compass Health).

While we agree with nurse prescribing of opioid analgesia in an emergency for no longer than 3 days we do not agree with extending this period or with nurse prescription of benzodiazepines in any circumstances. We also note both of these types of these medications have been found to be highly addictive and GPs have complained about being put under extreme pressure to prescribe them at times. It would be important to have some mechanisms to protect both consumers and specialist nurses from any misuse of these medications especially when they may be prescribed in the context of home based visits (14, Women's Health Action).

Issues surrounding prescription of controlled drugs are well-documented. It may well be appropriate for nurses to prescribe opioids in rural areas and/or in palliative care practice; however the Nursing Council must ensure that nurses have adequate training and support to recognise and appropriately deal with drug seeking behaviours and diversion of such medicines. It is critical that health professionals’ personal safety is protected (114, New Zealand National Committee of the Australian & New Zealand College of Anaesthetists (ANZCA)).

In general, Council agrees with the list of controlled drugs but there are a small number that Council believes should not be included.

- Benzodiazepines, along with opioids are the most commonly misused prescription drugs in New Zealand. Misuse frequently occurs when multiple drugs are misused, with the highest correlation between concurrent addiction to opioids and alcohol. Some benzodiazepines have limited licensed use in New Zealand and it is debatable if they should be on the list at all. If benzodiazepines remain on the list, they should be limited to a 30 day supply only.

- Oxycodone has high abuse potential as it is a potent opioid that is easily extracted from the long-acting tablet formulation for IV use. These tablets can be crushed, dissolved and injected, unlike other drugs that might need chemical manipulation before use. Oxycodone has no clinical advantage over other opioid analgesics and, as recommended by bpacnz (Best Practice June 2011) should only be used if morphine is not tolerated or not suitable. Council therefore believes serious consideration should be given to restricting oxycodone to medical practitioners only (85, Pharmacy Council of New Zealand).
**6.17 Conditions for prescribing controlled drugs (Question 2.19)**

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

Submitters were asked whether specialist nurse prescribers should be able to prescribe controlled drugs for a period longer than three days. A majority of submitters (56.1%) agreed. Those who supported a period of longer than three days commented that three days was too restrictive (12, 13, 53, 65, 156, 160, 164).

*First on call nurses cover weekends that extend beyond three days. NZRGPN would recommend extending the period of time to five days (180, New Zealand Rural General Practice Network).*

*In many circumstances, these medications may be required for a period of longer than 3 days and this should not inhibit the specialist nurse from prescribing them as it could delay appropriate and effective treatment to the client (192, Neonatal Nurse's College of Aotearoa - NZNO).*

Others thought specialist nurse prescribers should have the same conditions as other prescribers (128, 158, 173, 175, 192) and because they were working in a collaborative team they would be able to consult as appropriate with an authorised prescriber (40).

*If specialist nurse prescribers are allowed to prescribe certain controlled drugs, then they should have the same restrictions as other prescribers (128, Pharmacist and Therapeutics Special Interest Group of Paediatric Society of New Zealand).*

*Yes in conjunction with the doctors and clearly within their scope of practice. This could be particularly beneficial in palliative care (190, Te Awakairangi Health Network Clinical Governance Committee).*

Others expressed support for this in particular areas such as palliative care (79, 91, 99, 121, 123, 138, 140, 147, 151, 158, 166, 184, 190), pain management (38, 91), rural (99, 116, 147, 158), and for patients with chronic long term conditions (77, 110, 123, 167).

*The list of medications is appropriate, however the restrictions on prescribing them is prohibitive. For patients who have been prescribed a controlled drug for ongoing management of a chronic condition (e.g. low dose morphine elixir for shortness of breath) it would be appropriate for an appropriately trained nurse prescriber to provide repeat prescriptions, and titrate doses (13, Group of Nurses, DHB CNS).*
• Palliative care or remote settings will be limited by this restriction. Suggest that it may be an idea for employers to consider this in a hospital setting but why only controlled drugs – these are not the most dangerous and I don’t think there is any evidence to suggest nurses would be more prone to misuse than any other prescriber and therefore should not be specifically restricted
• Palliative care or areas in the rural sector where GP oversight is variable depending on availability and healthcare is provided mainly by RNs. Good to have flexibility
• One comment from Mental Health and Addiction that there is need for urgent action to address barriers of Misuse of Drugs Act (158, Canterbury Regional Directors of Nursing and Canterbury Postgraduate Nursing Education).

Codeine was identified as a particularly useful medicine for chronic pain management (96). Prescribing for addictions was also advocated for nurse practitioners who are presently prohibited under the Misuse of Drugs Act (1975) (76, 78, 158, 189).

Only when appropriate and within the specialist nurse’s area of practice. EG: Codeine can be very useful and may need broader prescribing for specialist nurse prescribers as it is often used in chronic condition pain management (96, MidCentral/ Wanganui DHB Regions Primary Health Care Nurse Practitioners and Interns Peer Review Group).

The College’s addiction medicine physicians note that, specific to the practice of addiction medicine in New Zealand:

There is an additional safeguard under the Misuse of Drugs Act 1975, section 24, in relation to prescribing for dependency: if the prescribing happens outside of a gazetted (i.e. specialist) addiction service, there must be a specialist letter of authority to the prescriber from the service including details of the prescribing parameters. In this way, it can be expected that all controlled drug prescribing in addiction would be overseen by a medical practitioner, either because the nurse prescriber works in the specialist service, or is authorised by that service.

At the time of this submission, the Misuse of Drugs Act limits controlled drug prescribing to medical practitioners only. It is understood that an amendment to this limitation has been proposed to allow for nurse prescribing. This submission allows for the possibility that this amendment will proceed (189, The Royal Australasian College of Physicians).

Yes –currently the barrier to nurse prescribing is being addressed in respect to the treatment of addiction i.e. opioid substitution treatment and withdrawal management. This is most urgent for nurse practitioner roles within the addiction specialty i.e. is limiting the first nurse practitioner with a particular focus on addiction within the broader mental health scope (76, Te Ao Māramatanga New Zealand College of Mental Health Nurses).

Extensions of the timeframes were suggested by some submitters. These included five days (57, 117), seven days or one week (5, 124, 140, 153, 64), nine days or three x three - day supplies (84) or two weeks (33, 154). One suggested up to 30 days (85) and some
suggested it should be longer in palliative care (28, 59, 75, 80). One submitter advocated no restriction (175).

Patient assessment and need should be the primary impetus for the prescription of controlled drugs. Stipulating a defined time duration may be limiting in some circumstances of addressing patient need (53, Nursing and Midwifery Board of Ireland).

Those who disagreed with a change to the three day restriction included some who commented that a doctor should be involved after three days (3, 4, 40, 63, 66, 82, 106, 112, 133, 142, 146, 169, 150, 178).

Patients should be going to their GP for longer term prescriptions for controlled drugs (82, College of Emergency Nurses New Zealand - NZNO).

All controlled drugs should be strictly monitored by doctors and/or nurses and if a patient requires it longer it should be a professional decision between doctor and nurse (4, Individual Nurse).

Others thought it was not within the skills of specialist nurse prescriber (21, 39, 54, 97) or not enough requirements were in place (62).

Specialty nurses should not be able to prescribe controlled drugs as this should be a medical practitioner or nurse practitioners responsibility. If a patient requires a controlled drug for pain relief their condition needs to be reviewed by an advanced practitioner (21, Individual Nurse).

Nurses should not be able to prescribe controlled drugs as the proposed training, registration and infrastructure are inadequate to safely audit and control prescribing (62, Individual Doctor).

Others were concerned about drug seekers (60, 170, 178, 181).

We are not supportive of this proposal, from a safety perspective (again, noting the limitations of our expertise with respect to safety and clinical practice). These are medicines with high ‘addictive’ properties, and also, in some cases, should not be for long-term use. So we are of the view that keeping the 3 days limit appears to be appropriate (181, PHARMAC).

One submitter stated that a three day supply was sufficient for the military (92), and another suggested additional authorisation (93).
7 Other comments

7.1.1 Incorporate health consumers when developing these changes

Two submitters commented on the need to involve the public or consumer perspectives.

We also support the intent of these changes, which is to make treatment more accessible to consumers. However, healthcare consumers require protection and the assurance that their care will be safe. We believe public understanding of expanded nursing roles needs to be built into patient information and informed consent procedures so that health consumers know who is prescribing the medications and that they are competent (credentialed or authorized) to do so. We also believe the additional training requirements are extremely important and must be clearly described in any legislative changes. Consumer movements have demanded more responsive and consumer centered health services and has challenged medical dominance in health care. This has contributed to the professional recognition and autonomy of nurses as health practitioners in their own right and contributed to an environment of expanding practice for nurses. The involvement of consumers in changes to health systems and the health professions is important. We urge you to ensure that these consultations make meaningful attempts to engage with consumers’ perspectives on this important proposal to expand nursing practice (14, Women’s Health Action).

Patient engagement and public involvement is critical in the acceptance of any new roles/scopes of practice and the submission does not provide evidence for this i.e. what does the international literature about the patient’s experience with non-medical prescriber such as community and specialist nurse prescribers (190, Te Awakairangi Health Network Clinical Governance Committee)?

7.1.2 The nurse practitioner role will be undermined by these changes

Some submitters felt that nurse practitioners should be authorised first before looking into registered nurse prescribing (153). Others were concerned that these proposals will undermine the nurse practitioner (32, 36, 82, 97, 102, 103, 157, 190, 195).

I am disappointed that the Nursing Council appears to be wholeheartedly supporting a change to the law without research being conducted in our health context (in the case of the “community nurse prescriber”). As well as basing the specialist nurse prescribing change on a small review of a trial that was conducted.

I am equally disappointed that the unique and autonomous role of the nurse practitioner appears to be continually undermined. The development of NPs in New Zealand has been slow and difficult due to lack of support by the governing bodies. I believe that the introduction of these lesser scopes continues to undermine their development and opportunities for employment as highly skilled practitioners that have the ability to reduce inequalities in access to health services and medicines.
The Nursing Council has set very stringent, demanding and exhaustive list of competencies, training and expectations on nurse practitioners and has made it very difficult to achieve this status. I feel that by allowing nurses to in essence the same role and same but abridged training as an NP but for less (and cheaper) training undermine the role of the NP as well as makes it easier to become a nurse prescriber instead. Leading to almost completely negating the role of NP in New Zealand.

I see a role for specialist nurse prescribers in areas of tertiary specialist practice, in this model they are a part of a highly skilled and specialised team. Who are able to monitor the practice and also the patient is managed by a team not just that nurse. I am concerned of the broad nature of the scope as it has no limits to what areas a nurse specialist may work in.

In this very tight fiscal environment it may be deemed that specialist nurse prescribers or even community nurse prescribers are “cheaper” than nurse practitioner but the overall product will end up in a further fragmented health system where people are treated in silos depending on their condition such as “diabetes” cardiac “renal” etc. as well as potentials for compromised patient safety (97, Individual Nurse Practitioner).

I believe instead of extending prescribing to CNS the same amount of energy and drive should be given to creating Nurse Practitioner internships as could be likened to Registrar training positions. I strongly believe adding more prescribing roles to nursing will detrimentally effect Nurse Practitioner growth in New Zealand, and there by further limit the ceiling to which nurse will be able to extend their practice. This will ultimately mean less potential benefits to delivery of health care.

Health managers will and are already saying “why should I support you to become a nurse practitioner if I can just employ you as a clinical nurse specialist with prescribing?” In fact I already know of nurse with Masters preparation and whose ambitions to be a Nurse Practitioner have been quashed by this very attitude by her managers. There is already significant confusion with regards to the roles and qualifications of nurses versus Nurse Practitioners and adding additional nurse prescribing roles will make things worse. In fact at a recent meeting with Nurse Practitioners even Des Gorman stated he found it difficult to differentiate between a CNS prescriber and a Nurse Practitioner.

I believe clinical nurse specialists are exactly the kinds of nurses who have the skills and drive to really develop advance nursing. I believe they should be given the opportunity of a Nurse Practitioner internship which would support them in a trainee prescriber role that was guaranteed to become a Nurse Practitioner role once they have qualified. Academic training would only be one year full time study to get their Masters above the current proposed prescriber CNS requirement. If this training was supported as part of their internship (as prescriber practicum etc.) I am certain under these circumstances they will find the further training required achievable while at the same time be in a developing role that is providing high quality service to their patients. This will therefore ensure advanced delivery of care in the near future.

Some may say a NP is a far broader role whereas a CNS has a narrow focus, What I say is that even if one prescribes in a narrower focus one absolutely needs to be able to prescribe on a broad background of knowledge as well as having in-depth knowledge in their specialty. Many patients being seen in specialist clinics are there precisely because they are very complex with many co-morbidities which mean they need specialised care to manage
their condition in conjunction with the underlying co-morbidities. Without understanding how these co-morbidities affect each other and recognising what needs to be done to manage the co-morbidities as well as the specific condition one would not be able to practice. Another Nurse Practitioner may practice with a broader focus but often that may mean managing more straightforward patients which do not need specialist intervention. These patients are often very well managed in primary care and do not require specialist input. I do not think one working in broad focus is more skilled than one in a narrow focus or visa versa, the roles are just different but both are working at a very advanced level.

One may describe Nurse Practitioner roles as broader as they look at the whole paradigm of care by addressing the wider determinants of health, population health and using a case management approach to care. However CNS would do that too by the fact they too are nurses and nursing models of care do tend to be more holistic and broad.

One may then argue that if one only employs a CNS prescriber then one will only have to pay a CNS rather than a Nurse Practitioner. Maybe this is one of the main driving factors for employers to not provide Nurse Practitioner trainee opportunity and have CNS roles instead. However CNS are still paid at the higher end of the scale and once they become prescribers one would expect they would want due financial reward for the considerable extra responsibility of prescribing and recognition of their advanced skills and subsequently that in future this would be put on the bargaining table. The total number of nurse prescribers will only be reality minor when considering the nursing workforce as a whole. I believe employing CNS prescribers instead of Nurse Practitioners will not save that much money but will add less value to health care provision because they will not have been given the opportunity and support to really work to the top of their ability (195, Individual Nurse Practitioner).

7.1.3 Funding for qualifications needed

A number of submitters commented on the lack of available funding for these proposals from HWNZ (38, 41, 94, 96, 165, 187).

I believe that we need to seek an assurance for extra funding from HWNZ to ensure nurses who choose to engage in the education required to obtain the required educational qualifications re extended scopes are guaranteed the funding to enable this to happen and individuals/communities will benefit from the new models of care (38, Individual Nurse).

No consideration has been given to increasing funding to support RNs undertaking the further study required and to ongoing mentoring/supervision that is mandatory. The document clearly states there is no additional funding available to support nurses wishing to advance on this pathway.

Within primary care Registered Nurses have applauded the opportunity to seek Health Workforce funding as it removes significant barriers to level 8 studies. Over the past 6-7 years we have seen a significant increase in nurses wishing to advance their practice in their areas of speciality e.g. long term conditions, advanced health assessment, etc. Concerns have also been raised re utilising the current level of funding to support nurses wishing to take on the advanced prescribing roles, plus subsequent funding to support mentoring/supervision by medical colleagues. We believe this would once again put barriers in place for other primary care nurses wishing to advance their practice having to compete
for this one source of funding and the potential for nurse prescribing papers being given greater priority (41, Primary Health Organisation).

7.1.4 Comments regarding specific areas

Several submitters made comments about specific areas of practice. One submitter expressed concern that the area of palliative care did not appear to be provided for in the consultation document. They expressed the belief that patients in this area would benefit from nurses’ ability to prescribe (94). One submitter felt further clarification was required about how the area of child health would be preserved in terms of specialist nurse prescribing (197). Four submitters expressed concern about the level of mental health education that would be provided as mental health and addiction conditions are often associated with physical health. They sought clarification about the inclusion of mental health conditions and therapeutic interventions in the training provided (35, 76, 78, 158). One submitter queried where aged care nurses would sit in terms of prescribing category (5, 195), as they may not necessarily work in the community and often do not have access to doctors to consult with on a regular basis. One submitter offered assistance in further developing a specific role for dermatology (177).

7.1.5 Incorporate skills and knowledge frameworks

One submitter suggested that further consultation was needed with the health sector to further develop scope, education and competency issues. They suggested that meeting with the National Nursing Consortium or nursing groups would be useful for developing specialty competencies (skills and knowledge frameworks) and medicines lists (159).

7.1.6 Align proposals and Ministry of Health policy

Seven submitters urged the Nursing Council to align with Ministry of Health policies and legislation when implementing registered nurse prescribing (57, 130, 131, 132, 149, 182, 187).

As this moves forward, it will be vital to attend to MoH policies and legislation to ensure compatibility with new prescribers (149, District Health Board; 182, Nursing and Midwifery Governance Committee- Hawke’s Bay DHB; 187, DHB Shared Services).

7.1.7 Access to laboratory testing

Several submitters mentioned the need to secure access to laboratory testing (57, 59, 75, 95, 106).

It should also be noted that this proposal does not take in to consideration the access to laboratory testing that would be required (57, District Health Board).
7.1.8 Develop guidance for prescribing and medicines management

One submitter suggested that the Nursing Council develop a guide to good prescribing practice as well as the proposed competencies (134). Another submitter suggested developing a publication about registered nurse responsibilities under the Medicines Act 1981 (187).

In addition to the proposed competencies for nurse prescriber, we suggest that the Council gives consideration to developing a guideline for appropriate nurse prescribing. This Office frequently refers to the Medical Council's statement on “Good Prescribing Practice” (April 2010), which we consider to be a helpful overview of the matters of which prescribers should be aware. A similar guideline for nurse prescribers could include advice, for example, on circumstances in which nurses should refer patients back to medical practitioners (134, Health and Disability Commissioner).

As preparation, suggest NCNZ communicates education around RN responsibilities under medicines act- publish something simple, along the lines of the NCNZ social media release. Need to cover off current routine administration as well as new prescribing responsibilities under legislation (187, DHB Shared Services).

7.1.9 Poor evidence provided to support these proposals

NZMA commented on the “weak” evidence provided by the Nursing Council to support these proposals.

The NZMA believes that any health policy change of this magnitude should be informed by the evidence. Our organisation is concerned that many of the sweeping claims in the proposals to support designated nurse prescribing are unsubstantiated or reflect weak evidence (grey literature and unpublished research theses). On occasions, the literature appears to have been misinterpreted. For example, potential benefits of more nurses prescribing include the claims of “reduced hospital admissions” and “savings in time and money for health consumers” yet no data (New Zealand or international) are provided to substantiate these claims.

Other justifications being advanced for independent nurse prescribing include claims that “many patients are unable to enrol in general practices and others cannot make timely appointments to see a General Practitioner”. Once again, no empirical data are provided to support these statements. Later in the consultation document, it is stated that “the cost of preparing experienced nurses to expand their role is cost effective” but no supporting evidence is provided (69, New Zealand Medical Association).
8 Appendix 1: List of submitters

1. Individual Nurse
2. Rural Women New Zealand
3. The Pharmacy Defence Association of New Zealand (Inc.)
4. Individual Nurse
5. Individual Nurse
6. Individual Doctor
7. School of Nursing, Otago Polytechnic
8. Individual Nurse
9. Cancer Nurses Section NZNO
10. Individual Nurse
11. Whanganui Regional Primary Health Organisation
12. Individual Nurse
13. Group of Nurses, DHB CNS
14. Women's Health Action
15. Individual Nurse
16. Individual Nurse
17. Tairawhiti District Health Board
18. Group of Nurses
19. Wintec (Student Health)
20. Individual Nurse
21. Individual Nurse
22. Individual Nurse Practitioner
23. Group of Nurses, Primary Health
24. Individual Doctor
25. Individual Nurse
26. Group of Nurse Practitioners
27. Health Care Development
28. Individual Nurse
29. Individual Nurse Practitioner
30. Individual Nurse
31. Individual Doctor
32. Individual Nurse
33. Individual Nurse
34. Group of Nurses
35. Group of Nurses
36. NZ College of Primary Health Care Nurses, NZNO
37. Individual Nurse
38. Individual Nurse
39. AUT, Faculty of Health & Environmental Sciences
40. Department of Corrections Health Services
41. Primary Health Organisation
42. Primary Health Organisation
43. Group of Nurses, DHB
44. Taranaki District Health Board
45. Individual Nurse
46. Individual Nurse
47. Café Incorporated (known as Café for Youth Health)
48. Individual Nurse
49. Kimi Hauora Wairau Marlborough Primary Health Organisation
50. Waikato District Health Board
51. Individual Nurse
52. Group of Nurses
53. Nursing and Midwifery Board of Ireland
54. Group of Nurses
55. School of Nursing, University of Auckland
56. College of Nurses Aotearoa New Zealand
57. District Health Board
58. Individual Nurse
59. Primary Health Organisation
60. Pharmacy Guild of New Zealand
61. Individual Doctor
62. Individual Doctor
63. Individual Doctor
64. Individual Nurse
65. Aged Care Organisation
66. Individual Nurse
67. Training and Development Services (TADS) Behavioural Change Training
68. Individual Doctor
69. New Zealand Medical Association
70. Rakaia Medical Centre Trust
71. Group of Nurses, Primary Health
72. Family Planning
73. Bay of Plenty District Health Board
74. Group of Nurses
75. Primary Health Care Leadership across Waitemata and Auckland districts
76. Te Ao Māramatanga, New Zealand College of Mental Health Nurses
77. Group of Nurses, DHB
78. Matua Raki - National Addiction Workforce Development
79. CPIT - Department of Nursing
80. District Health Board
81. Individual Nurse
82. College of Emergency Nurses New Zealand - NZNO
83. Individual Nurse Practitioner
84. Individual Nurse
85. Pharmacy Council of New Zealand
86. CAPA - Clinical Advisory Pharmacists
87. Public Health Service
88. Individual Nurse
89. Individual Nurse
90. Mercy Hospice Auckland
91. Group of Nurses, DHB
92. New Zealand Defence Force
93. Group of Nurses, CNS
94. Wairarapa District Health Board
95. Group of Nurses, DHB
96. MidCentral/ Wanganui DHB Regions Primary Health Care Nurse Practitioners and Interns Peer Review Group
97. Individual Nurse Practitioner
98. NZNO (Diabetes Nurse Specialist Section)
99. New Zealand Institute of Rural Health
100. Pharmacists and Therapeutics Special Interest Group of the Paediatric Society of New Zealand- Submission A
101. Individual Nurse
102. Individual Nurse
103. Individual Nurse
104. Unitec Institute of Technology
105. Individual Nurse
106. New Zealand Sexual Health Society (NZSHS)
107. Individual Pharmacist
108. Individual Doctor
109. Individual Nurse
110. Group of Nurses, CNS
111. Waitemata District Health Board
112. Individual Nurse
113. Individual Nurse
114. New Zealand National Committee of the Australian & New Zealand College of Anaesthetists (ANZCA)
115. Individual Pharmacist
116. Non Government Organisation
117. Individual Nurse
118. Group of Nurses, DHB
119. Individual Nurse
120. Individual Nurse
121. Massey University
122. District Health Board
123. Individual Nurse
124. New Zealand Home Health Association Inc.
125. Group of Nurse Practitioners
126. Auckland Sexual Health Service
127. Group of Pharmacists
128. Pharmacist and Therapeutics Special Interest Group of Paediatric Society of New Zealand- Submission B
129. Individual Doctor
130. Hawke's Bay District Health Board
131. Individual Nurse
132. Health Hawke's Bay (PHO)
133. Individual Nurse
134. Health and Disability Commissioner
135. Council of Medical Colleges in New Zealand
136. Group of Nurses, Public Health
137. Nurse Practitioner New Zealand (NPNZ)
138. District Health Board
139. Nurse Education in the Tertiary Sector (NETS)
140. Palliative Care Nurses New Zealand
141. Immunisation Advisory Centre
142. Individual Nurse
143. The Royal Australian & New Zealand College of Psychiatrists
144. Group of Nurses, Community Health
145. Individual Nurse
146. Group of Nurses, DHB
147. Rural Canterbury Primary Health Organisation
148. Government Agency
149. District Health Board
150. Compass Health
151. New Zealand Nurses Organisation
152. Medical Council of New Zealand
153. Nurse Maude Association
154. Individual Nurse
155. Auckland School Nurses Group
156. CMDHB School Health Awareness Raising Group (SHARP)
157. Individual Nurse
158. Canterbury Regional Directors of Nursing and Canterbury Postgraduate Nursing Education
159. Mary Potter Hospice
160. Group of Nurses, CNS
161. Auckland Diabetes Centre Specialist Nurses
162. Ear Nurse Group NZ/Aotearoa
163. Eastern Institute of Technology
164. Group of Nurses, DHB
165. Victoria University of Wellington
166. Group of Nurses, Primary Health
167. Non-government organisation
168. New Zealand Society for the Study of Diabetes
169. Individual Nurse
170. Health Repora
171. Te Omanga Hospice
172. Abortion Law Reform Association of New Zealand
173. New Zealand Hospital Pharmacists' Association (NZHPA)
174. Individual Pharmacist
175. Individual Nurse
176. Individual Pharmacist
177. New Zealand Dermatological Society
178. Pharmaceutical Society of New Zealand
179. Midcentral District Health Board- Nursing
180. New Zealand Rural General Practice Network
181. PHARMAC
182. Nursing and Midwifery Shared Governance Committee- Hawke's Bay DHB
183. New Zealand Private Surgical Hospital Association- Directors of Nursing group
184. Individual Nurse Practitioner
185. Royal New Zealand Plunket Society Incorporated (Plunket)
186. New Zealand Society of Anaesthetists
187. DHB Shared Services
188. Midwifery Council of New Zealand
189. The Royal Australasian College of Physicians
190. Te Awakairangi Health Network Clinical Governance Committee
191. Individual Nurse
192. Neonatal Nurse's College of Aotearoa- NZNO
193. Council of Deans of Nursing and Midwifery, Australia and New Zealand
194. The Royal New Zealand College of General Practitioners
195. Individual Nurse Practitioner
196. Primary Health Organisation Clinical Governance Group
197. Group of Nurses, DHB
### 9 Appendix 2: Responses to consultation questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Not specified</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.1</strong> Do you agree with the proposal that suitably qualified and</td>
<td>157</td>
<td>15</td>
<td>2</td>
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<tr>
<td>experienced registered nurses be able to prescribe a limited list of</td>
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<td>medicines to treat minor ailments and infections, and to promote health?</td>
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<td><strong>1.2</strong> Do you agree that community nurse prescribing will enable</td>
<td>153</td>
<td>15</td>
<td>0</td>
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<tr>
<td>patients to receive more accessible, timely and convenient care?</td>
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<tr>
<td><strong>1.3</strong> Do you consider the title “community nurse prescribing”</td>
<td>45</td>
<td>119</td>
<td>2</td>
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<tr>
<td>adequately describes and informs the public and other health</td>
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<td>professionals of the breadth of this prescribing authority?</td>
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<td><strong>1.4</strong> Do you agree with the suggested wording changes to the</td>
<td>127</td>
<td>42</td>
<td>1</td>
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<tr>
<td>registered nurse scope of practice and with a prescribing authorisation</td>
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<td>being included in the scope of practice of registered nurses with</td>
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<td>community nursing prescribing authority?</td>
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<tr>
<td><strong>1.5</strong> Do you agree that the proposed education and training for</td>
<td>64</td>
<td>93</td>
<td>8</td>
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<td>community nurse prescribing is consistent with their scope of practice</td>
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<td>and their prescribing authority, and will enable them to demonstrate</td>
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<td>competent and safe prescribing practice?</td>
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<td><strong>1.6</strong> Do you agree with the course standards for community nurse</td>
<td>78</td>
<td>78</td>
<td>8</td>
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<td>prescribers?</td>
<td></td>
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<td><strong>1.7</strong> Do you agree with the competencies for community nurse</td>
<td>97</td>
<td>60</td>
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<td>prescribers?</td>
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<td><strong>1.8</strong> Do you agree with the entry criteria for community nurse</td>
<td>104</td>
<td>60</td>
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<td>prescribing courses?</td>
<td></td>
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<td><strong>1.9</strong> Do you agree with the ongoing continuing competence requirements</td>
<td>113</td>
<td>43</td>
<td>3</td>
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<tr>
<td>for community nurse prescribers?</td>
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<tr>
<td><strong>1.10</strong> Do you agree with the proposed list of prescription medicines</td>
<td>78</td>
<td>78</td>
<td>1</td>
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<td>that nurses with community prescribing rights will be able to prescribe</td>
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<td>as designated prescribers?</td>
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<tr>
<td><strong>1.11</strong> Do you agree that community nurse prescribers should be able</td>
<td>137</td>
<td>23</td>
<td>1</td>
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<tr>
<td>to access this list of non-prescription medicines?</td>
<td></td>
<td></td>
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<tr>
<td><strong>2.1</strong> Do you agree with the proposal that suitably qualified and</td>
<td>162</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>experienced registered nurses be able to prescribe from the</td>
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<td>specialist and community nurse prescribing lists of medicines?</td>
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<td><strong>2.2</strong> Do you agree that specialist nurse prescribing will enable</td>
<td>166</td>
<td>10</td>
<td>0</td>
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<tr>
<td>patients to receive more accessible, timely and convenient care?</td>
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<tr>
<td><strong>2.3</strong> Do you consider the title “specialist nurse prescribing”</td>
<td>88</td>
<td>82</td>
<td>3</td>
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<tr>
<td>adequately describes and informs the public and other health professionals of the breadth of this prescribing authority?</td>
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</tbody>
</table>
2.4 Do you agree that nurses with specialist nurse prescribing authority should be required to work in a collaborative, multidisciplinary team?

| 163 | 9 | 1 |

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

| 154 | 12 | 2 |

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?

| 100 | 44 | 10 |

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

| 123 | 35 | 2 |

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?

| 153 | 14 | 2 |

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

| 154 | 12 | 1 |

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

| 159 | 8 | 1 |

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

| 114 | 56 | 2 |

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

| 135 | 29 | 2 |

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?

| 101 | 59 | 2 |

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

| 39 | 108 | 0 |

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

| 103 | 35 | 1 |

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?

| 164 | 3 | 0 |

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?

| 131 | 28 | 1 |

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?

| 91 | 67 | 4 |

Note the response to question 2.6 can be found under section 6.5.