Application for consideration of designated prescribing rights

Registered nurses practising in primary health and specialty teams

September 2014
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Part 1

1. Name and description of registration body

The Nursing Council of New Zealand (the Council) is the authority under the Health Practitioners Competence Assurance Act (HPCA Act) (2003) responsible for ensuring the health and safety of the public is protected by ensuring nurses are competent and fit to practise. The Council regulates 51,406 nurses with practising certificates by:

- specifying scopes of practice
- prescribing qualifications for each scope of practice
- setting standards, accrediting and monitoring education programmes
- registration and authorisation of scope of practice
- issuing practising certificate and setting standards and monitoring of continuing competence
- setting standards of clinical competence, cultural competence and ethical conduct
- managing nurses reported to the Council for conduct, competence and health concerns.

The Council is responsible for ensuring the safe practice of nurses who are already authorised to prescribe (nurse practitioners and designated prescribers: registered nurses practising in diabetes health) and for all nurses who manage and administer prescription medicines and controlled drugs.

The Council is committed to a safe regulatory framework to ensure the delivery of effective and efficient health care to all New Zealanders in a changing health care environment.

2. Name and description of proposing body

The Nursing Council of New Zealand is the proposing body. The Council has undertaken the research, background work and consultation necessary as part of the application.

The Council has worked on the extension of prescribing with the Office of the Chief Nurse Business Unit, Ministry of Health. This partnership is important in positioning nurse prescribing as a central government objective and raising awareness of the benefits of the proposal with policymakers, funders and employers.

Additionally in developing the current application, the Council consulted widely with a range of stakeholders (see Section 9). This consultation was important to ensure the proposal is broadly acceptable to the sector and aligns with legislation, funding and policy direction.

The Council is supported in this application by the National Nursing Organisations (NNOs). The NNOs are professional groups which represent nurses including:

- the New Zealand Nurses Organisation (NZNO)
- the College of Nurses Aotearoa
- Te Ao Māramatanga (New Zealand College of Mental Health Nurses)
• the Council of Deans of Nursing
• Nurse Educators in the Tertiary Sector
• District Health Board Directors of Nursing
• Nurse Executives of New Zealand (NENZ), and
• Te Kaunihera O Nga Neehi Māori O Aotearoa (National Council of Māori Nurses).

3. Short description of application

This application is for designated prescribing rights for experienced registered nurses who hold a postgraduate diploma in registered nurse prescribing. These nurses will be practising in primary health and specialty teams, and working with patients with long-term and common conditions. They will prescribe from a limited list of commonly used medicines.

Registered nurses authorised to prescribe will work with a collaborative, multidisciplinary team and manage and monitor patients with these conditions in outpatient or general practice clinics, or by providing home-based care. They will be able to seek advice or refer patients with complicated, complex or uncertain health conditions which are beyond their experience and education to a medical or nurse practitioner within the team.

The registered nurse authorised to prescribe will have:

1. a minimum of three years’ experience in the area of prescribing practice
2. completed a postgraduate diploma in registered nurse prescribing for long-term and common conditions (e.g. asthma, diabetes, hypertension)
3. completed a prescribing practicum with a designated authorised prescriber (a medical or nurse practitioner) as part of the postgraduate diploma
4. a limited list of medicines from which they can prescribe within their competence and area of practice
5. a condition included in their scope of practice to complete a further 12 months of supervised prescribing practice when they are authorised by the Council to prescribe
   and
6. ongoing competence requirements for prescribing.

This application builds on the success of the diabetes registered nurse prescribing project. The New Zealand Society for the Study of Diabetes (NZSSD) and Health Workforce New Zealand (HWNZ) initiated a Diabetes Nurse Prescribing Demonstration Project in 2011. To date 27

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1 The Council is not seeking to include supervision requirements within the regulation for designated prescribing but would use provisions under the HPCA Act.
registered nurses have been authorised to prescribe 26 medicines in diabetes health. Further information on the evaluation of these nurse prescribers is included in section 5.

In 2011 the Minister of Health invited the Council to make a broader application to extend prescribing rights for suitably qualified registered nurses. Prescribing authority for one disease state (diabetes) is too limiting as many patients have multiple health conditions. The Council believes a new designated prescriber regulation for registered nurses practising in primary health and specialty teams would replace the Medicines (Designated Prescriber—Registered Nurses Practising in Diabetes Health) Regulations 2011.

The extension of nurse prescribing comes as newer, more flexible models of care are being developed to improve access to health care services and the timeliness and convenience of services. The rationale for enabling registered 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 Council has developed a proposal for registered nurse prescribing which meets the Council’s statutory responsibility to protect public safety, fits with relevant legislation and has the support of a broad section of the health sector. The Council completed an extensive consultation about registered nurse prescribing before setting the qualification, education standards and competencies included with this application.

The Council also consulted on a second proposal for registered nurse prescribing (community nurse prescribing) that focuses on prescribing for the purposes of health promotion, disease prevention and the assessment and treatment of minor ailments and illnesses. The community nurse prescribing proposal included a more limited number of medicines and a lower educational requirement. The Council intends to further develop this proposal in the next six months before making a second application for designated prescribing rights for community nurse prescribers.

The Council believes this proposal for registered nurse prescribing in primary health and specialty teams complements the nurse practitioner scope of practice. Nurse practitioners are experienced registered nurses who have also completed a master’s degree that includes prescribing papers and have been authorised to practise in an advanced scope of practice. Nurse practitioners became authorised prescribers in July 2014 when the Medicines Amendment Bill was implemented. Nurse practitioners may practise independently across a range of settings. They lead teams and may provide treatment for more complex patients.

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2 The transition for registered nurses who have this prescribing authority is discussed in section 9 under “education and training”.
4. **Principal contacts of the registration body**

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Part 2

5. Rationale and business case considering risks and benefits

Consumer benefits and accessibility

Extended nurse prescribing has the potential to improve access to a range of services for the New Zealand health consumer. These include health services within primary health care and outpatient settings. Specific settings identified in this proposal are long-term condition clinics including diabetes, hypertension, respiratory diseases including asthma and COPD, cardiology and ophthalmology. This proposal also encompasses prescriptive authority for health promotion, disease prevention, and the assessment and treatment of minor ailments and illnesses. This also enables nurses to also prescribe contraceptives and vaccines, and for common skin conditions and infections. This prescriptive authority has the potential to enable greater access to medicines for consumers in general practice, family planning, sexual health, public health, district and home care, and rural and remote areas.

Nurses are increasingly being asked to expand or “work to the top of” their scope of practice. New models of care are being developed and care delivery is being reshaped so patients are being seen by the most appropriately skilled health professional for their needs.

Nurses have a broad scope of practice that covers the lifespan and most health conditions. They are the largest group of regulated health professionals and they work alongside medical practitioners and other members of the multidisciplinary team. They already have a role in administering medicines to patients and educating patients about medicines. It is increasingly common for nurses to supply and administer medicines under a standing order\(^3\). Nurses provide nurse-led clinics for some patients and prescribe by proxy (the nurse assesses the patient and determines the medicine to be prescribed but the medical practitioner signs the prescription). These changes have resulted from the need for more timely and convenient patient access to medicines, a desire to make better use of nurses’ skills and knowledge, and because of medical practitioner shortages (particularly in remote areas) and workload.

Registered nurses frequently take on extended roles, particularly in the management of chronic disease and long-term conditions, freeing up medical practitioners to concentrate on diagnosis and management of more complex cases and disease complications. Some registered nurses who work in specialist teams or roles already take responsibility for managing the care of many patients with long-term conditions, and taking on responsibility for prescribing common medications is a natural extension of that role. Working as part of a multidisciplinary team ensures professional support and advice are available.

\(^3\) A written instruction issued by a practitioner or registered midwife, in accordance with any applicable regulations, authorising any specified class of persons engaged in the delivery of health services to supply and administer any specified class or description of prescription medicines or controlled drugs to any specified class of persons, in circumstances specified in the instruction, without a prescription (Medicines Act 1981, section 2)
Prescribing authority will be more convenient for patients (Carey et al. 2014), nurses and medical practitioners, particularly for routine monitoring and continuation prescribing. It will mean registered nurses are able to make a greater contribution to patient care, particularly in common and long-term condition management. Prescribing authority will ensure clearer competency and accountability for the registered nurse’s prescribing decisions.

The ability of the registered nurse to prescribe will ensure greater continuity of care and convenience for patients who would no longer need a second appointment with a medical practitioner specifically for a prescription. Nurses frequently have more time to spend with patients which can ensure problems are identified early, leading to better management of a condition. More nurses with greater knowledge of pharmacology have the potential to improve medication management and patient adherence to medication plans (Carey et al. 2014). Non-adherence to medicines can lead to poorer outcomes for the patient and costs to the health system when there is secondary illness or admission to hospital. Nurses have skills they can bring to working partnerships with patients where treatment plans are negotiated and agreed, and self-care is encouraged and enabled.

Some practice examples of the benefits registered nurse prescribing can make to patient care are included in Appendix 1: Consultation on two proposals for registered nurse prescribing (see page 33).

Some of the potential benefits for consumers of registered nurses prescribing are:

- increased flexibility in the delivery of services
- increased access to services and medicines, particularly in rural and remote communities
- improved patient education and medicines concordance (patients continuing to take or completing courses of medicines that reduce the risk of further illness or deterioration)
- improved management of demand for primary services
- reduced hospital admissions
- savings in time and money for health consumers.

Nurse prescribing has the potential to save costs for the patient (transport, time and money) and for the health system as a whole by freeing up medical practitioners’ time to see more acute and complex patients, and by reducing acute demand and hospital admissions by timely treatment in the community.

During the consultation a number of submitters identified many of these benefits in their submissions to the Council (see Appendix 2: Analysis of Submissions, pages 70-72).
New Zealand: Registered nurses practising in diabetes health

The extension of prescribing into the diabetes registered nurse role was considered to be beneficial by the nurses, their supervisors (medical practitioners) and patients in improving the quality of patient care, enhancing service delivery and generally increasing the capability of the diabetes workforce.

The evaluation of the demonstration project found that diabetes nurse prescribing was safe, of good quality and clinically appropriate (Wilkinson et al., 2011; Wilkinson et al., 2013). Diabetes physicians had fewer interruptions to their work as nurses were able to initiate prescriptions for patients. Patients were highly satisfied with the change and reported that it was more convenient, saved them time and they experienced fewer delays. All members of the team were supportive of diabetes nurse specialist prescribing.

Ninety-five per cent of patient survey respondents indicated it is ‘definitely more convenient’ to get a prescription from a DNS than from a specialist or GP, saying they “didn’t have to wait for the doctor to be available just to sign when it was already explained by the nurse” (Patient survey response). The importance of convenience was reiterated repeatedly in the short answer survey responses, and also in the follow-up telephone interviews: “For me it’s convenience. Because the thing is with the specialist doctors, you generally only see them every six months to a year, but with the nurses it’s much easier to get in to see them” (Patient interview 17).

Convenience and the cost associated with getting a prescription from a GP were often linked by respondents, who also made mention of the added cost associated with taking time off work to pick up a prescription from a GP: “I think it was really good. You don’t have to make a second trip somewhere else and take more time off work and all that. It was so much more convenient, because you can talk about the different things and then they can write the script then and there” (Patient interview 18). “Time is money. I have children at school that I have to get back to pick up, and things like that, and if I’m hanging around and hanging around it was definitely a big thing. It [the consultation] was still fresh in my mind and it was done” (Patient interview 9).

(Wilkinson et al. 2011, p 37).

A physician explained that if a patient can receive a prescription directly from the DNS [Diabetes Nurse Specialist], it removes a barrier to their access to medicines: “But every extra step is a potential barrier and particularly when you’re talking about an ambivalent patient. You know ones who really don’t want to start insulin but sort of acknowledged they probably should do, any extra step is a deterrent” (Doctor 3/1ii).

For the sites that accept self referral the perception of improved access to medicines was clear. One nurse gave the following example: “We’ve got the odd person who might walk in who’s in the area for seasonal work, doesn’t have a primary care provider in the area, needs a prescription for medicines and knows that they can come to a diabetes centre. So I think that has enabled people to have better access to care that they may not necessarily, it might have been more problematic for them otherwise” (DNS 3/2ii).
Another example of improved access is for people with little money: “particularly young people or people with no money or socially challenged or whatever, we can just give them a script on the spot and because you know they haven’t got money, they’re not going to go to the GP, they’re going to run out of whatever and so that’s been a huge, you know, specific to the community I guess” (DNS 3/3ii).

Short answer patient survey responses (n = 31) and the patient interviews repeatedly mentioned that no costs or payment for prescriptions were an important difference between receiving a prescription from a GP and a prescribing DNS: “But the other thing is cost. My GP, it costs me a lot of my money even if I ring up and ask for a script” (Patient interview 17). (Wilkinson et al. 2011, pp. 45-46).

Diabetes registered nurse prescribers (in the report on the 2012 managed national roll-out) universally described improved access for patients to diabetes medicines that was timely and cost efficient for the patient and the nurse. There was a reduction in delays for accessing prescriptions, or decisions about treatment changes that may or may not have required a prescription, for example a dose change. These reductions were considerable, some nurses suggesting that before they were able to provide a prescription some patients may have been required to wait up to a fortnight before being started on a medication. In addition, appropriate dosing and optimisation of drug therapy was able to occur (Budge & Snell, 2013, p14).

This report includes case studies of nurses employed in a variety of ways, e.g. by DHBs practising in specialist outpatient services or by DHBs but practising in rural hospital outpatients and visiting general practices, directly by Primary Health Organisations/general practice or non-governmental organisations. “[The diabetes nurses], in prescribing they have taken on what is traditionally seen as part of the medical role, they are approaching their prescribing practice as nurses. They continue to assess, communicate, educate and support holistically but with added knowledge, understanding and capability. Their attitude towards prescribing is one of caution and consideration with the result that they feel no risks are being taken. They are consulting when necessary and they feel confident that patients are benefiting from a more thorough, timely and cost-efficient process. All nurses feel like they have more to offer in consultations with respect to patient assessment, patient education and medication review and also in sharing their knowledge with other nurses and the primary care practitioners they provide education and support for” (Budge & Snell, 2013, p16).

The report recommendations include the following before a nurse commences prescribing: experience in the specialty and collegial relationships be established, a formal and thorough prescribing practicum, relevant structured education, and a commitment to support in the long term from the prescribing supervisor (Budge & Snell, 2013, p17).
Potential risks of nurse prescribing

The potential risks of nurse prescribing were identified by a very small number of submitters to the Council's consultation process. The risks they identified were related to patient safety, nurses’ inability to diagnose, potential for inappropriate prescribing, and fragmentation of care. These concerns and how they are responded to by the Council are discussed further in section 9.

Other submitters identified risks related to the registered nurse prescribing model not being adequately supported because of the business model in primary care, inadequate clinical governance structures or lack of ongoing support for nurse prescribers. Some of the recent international literature is discussed below where both the benefits and risks are considered.

International evidence supports the safety of nurse prescribing. Registered nurse prescribing is well established in some countries, notably the United Kingdom (UK), and has generally been seen as positive (Latter & Courtenay, 2004) (Van Ruth et al., 2008). Nurse prescribing from a defined formulary is well established internationally. Prescribers are experienced nurses who undertake thorough training and are nationally regulated to ensure the safety of patients.

In the UK independent nurse prescribers have been able to prescribe from the entire British National Formulary since 2006. In reality they are cautious prescribers who self-restrict their prescribing and prescribe for specific conditions and for individual patients they know (Bowskill, 2009, p. 1).

Hacking and Taylor (2010) evaluated non-medical prescribing (nurse and pharmacist) in the National Health Service within the north-west of England. They reported a positive impact on the quality of patient care, patient access to medicines and a better patient experience as they were not passed from one health care professional to another. It was reported as having a positive impact whether a prescription was generated or not. Non-medical prescribers reported positive impacts on patient safety including identifying contraindications, and correcting or changing existing prescriptions. They also estimated significant time saving for patients although it made their own patient care more time consuming.

Latter et al. (2012) completed an evaluation of nurse and pharmacist independent prescribing that confirmed the positive impact of nurse prescribers and also found their prescribing decisions to be clinically appropriate. Watterson et al. (2009) examined the expansion of nurse prescribing in Scotland and found similar benefits but also organisational, institutional and resource barriers.

Carey et al. (2014) explored nurse prescribing for patients with respiratory conditions in the east of England. “By prescribing, participants reported that they were able to improve access to medicines, convenience for patients and enhance service efficiency. They were able to overcome problems with existing services in relation to a) frail and housebound patients, b) gaps in routine care, and c) access to treatment in hospital. Rapid detection and treatment of
acute episodes or exacerbations of respiratory conditions was a care priority for all participants and was one of the most significant areas to which prescribing contributed” (Carey et al., 2014, p4).

a. **Size of prescribing profession:** how many of the group will take up the prescribing role and what is the long-term vision for likely numbers of prescribers?

There are 48,406 practising registered nurses in New Zealand. It is envisaged that only a small proportion of registered nurses will seek this prescriptive authority over a 10 year period (1-2%) (approximately 500-1000 nurses). This is based on international and New Zealand evidence. The first nurse was given prescribing authority in New Zealand 13 years ago. Since then 125 nurse practitioners and 27 registered nurses working in diabetes health have gained prescribing rights. New Zealand has achieved 0.3% of practising nurses authorised to prescribe4.

This compares with the UK where there are approximately 20,0005 independent and supplementary nurse prescribers out of 659,763 registrants (3%) and over 30,0006 community nurse prescribers (4.5%). An Bord Altranais (Irish Nursing Board) has 67,1307 active registrants. Five hundred and forty-five nurses8 or 0.8% of the workforce have registered as prescribers since 2008. In both of these countries nurse prescribing has been actively supported by the Government. Even with this active government support, the proportion of nurses prescribing remains small compared with the total nursing workforce.

In Australia there are 788 prescribing nurse practitioners and 804 registered nurses authorised to supply schedules medicines (rural and isolated practice) (Nursing and Midwifery Board of Australia, 2012). The number of nurse prescribers in Australia (677 in Queensland) represents 0.66% of the registered nurse workforce9.

It is estimated there may be approximately 100 registered nurses in New Zealand who are qualified and are in a position where they would be supported to prescribe as soon as a regulation is put in place. This is based on the response to the HWNZ Diabetes Registered Nurse prescriber priority 2014. The aim of this priority is to have 100 nurses authorised or working towards authorisation. This initiative has identified over 100 potential nurse prescribers but barriers to achieving this number include nurses needing to complete further education, lack of mentor and employer support, and reluctance by the nurses themselves to take on a prescribing role.

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4 Based on 51,406 nurses with practising certificates at 31 March 2014.
5 Royal College of Nursing (2012a).
6 Royal College of Nursing (2011).
8 Personal communication with An Bord Altranais.
9 This is based on 241, 484 registered nurses. If 32,825 registered nurse midwives are included the rate is lower.
b. **Implications for infrastructure**: including IT and electronic ordering of diagnostics for monitoring medication outcomes;

Registered nurse prescribers will need to be able to access health records and to order diagnostic tests, particularly blood tests. Many nurses are already situated within health teams and health services where these activities are currently facilitated for other prescribers. Health policy supports access to laboratory diagnostic services on written referral from a registered medical practitioner or other practitioners (Ministry of Health, 2011). There may need to be extension contracts or policy within District Health Boards (DHBs) to ensure diagnostic tests are available to registered nurse prescribers.

c. **Implications for pharmacy and diagnostics budget**;

There is an increasing demand for health services and for pharmaceuticals. At present, pharmacists dispense around 65 million prescription items (Ministry of Health, 2012). The Medical Council annual reports from 2005 to 2011 indicate the number of medical practitioners with practising certificates has increased by 2,459. However, even this significant increase in the medical workforce (22%) is not keeping pace with demand. Many patients are unable to enrol in general practices and others cannot make timely appointments to see a general practitioner (Ministry of Health, 2013).

After workforce, medicines are the largest area of health spending (Ministry of Health, 2011). The number of prescriptions is growing each year because of increasing demand due to an ageing population, increasing prevalence of chronic disease and their related complications, a greater emphasis on long term condition management and new treatment guidelines. PHARMAC reported a $783.6.4 million pharmaceutical expenditure for the year 2012-2013, an increase of $6.2 million over the previous year’s expenditure, and that 42.2 million funded prescriptions were written (a 3.5% increase) (Pharmaceutical Management Agency, 2013).

The introduction of more nurse prescribers will add to the total number of prescribers. Some of the pharmaceuticals nurses will be able to prescribe under this proposal are already being supplied to patients by nurses under standing orders or through prescribing by proxy\(^{10}\).

In the 2012 national roll-out of the diabetes registered nurse prescribing evaluation report (Budge & Snell, 2013) a medication change was made by a nurse prescriber during 57% of consultations. “Prescriptions were provided during 857 (33%) of the contacts with patients and of these, 402 (47%) were for repeat medications only, 323 (38%) were for new medications only and the remaining 132 (15%) were for new and repeat medications” (p42). Nurses also discontinued 178 medicines. In the majority of cases prescribing decisions involved titration of already prescribed insulin and oral glycaemic agents.

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\(^{10}\) The nurse assesses the patient and makes a prescribing decision but the doctor signs the prescription.
Drennan et al. (2014) analysed the primary care prescription database (2006-2010) in the UK. They found only 43% of nurses who were qualified were prescribing and nurses prescribed 1.5% of the total items prescribed in primary care. The categories from which independent nurse prescribers prescribed the most were penicillins, dressings (not a category in NZ), adrenoreceptor agonists, non opioid analgesics and devices. Emergency contraceptives, drugs for threadworm, medicated stockings, oils and dressings were the categories from which nurses made the greatest contribution to prescribing in primary care. There did not appear to be significant prescribing for patients with chronic diseases.

UK evidence suggests nurses are conservative prescribers (i.e. prescribe less often and fewer items than medical prescribers) and they tend to prescribe according to recommended best practice (Bowskill, 2009, p1).

Gielen et al. (2014) undertook a systemic review of studies exploring the effects of nurse prescribing and patient outcomes, and found very few differences in the numbers of medicines per visit between nurses and physicians.

Improving access for patients to medicines may increase costs but it is anticipated this would be offset by the benefits of decreasing costs to the patient and to other parts of the health system.

It is beyond the scope of the Council to quantify the potential cost benefits to the health system of these proposals. The Council has already outlined some of the potential benefits which include saving patients’ time and money, savings through improved efficiencies in service delivery as shown in the diabetes nurse prescribing projects, enabling better management of primary demand for services and preventing some secondary acute demand.

   d. Relationships with other providers and systems for communication between providers: e.g. shared patient record;

Registered nurses with prescribing authority will work with multidisciplinary teams including an authorised prescriber. The Competencies for nurse prescribers (Appendix 4) identify a requirement for effective relationships and communication with other prescribers and members of the team. Experience from the diabetes nurse prescribing projects showed multidisciplinary team functioning was enhanced and effective communication was maintained. It is anticipated that nurse prescribers will use a variety of communication techniques. Ideally they would use a shared patient record but if that was not available they would use other mechanisms to communicate with other prescribers including phone calls, emails or letters.

   e. Communal harm: The possibility of community harm resulting from wider use of the medicines in question, e.g. the development of bacterial resistance to antibiotics;

The Council is aware of the possibility of communal harm from wider use of medicines, particularly antibiotics. For this reason the Council has limited the antibiotics on the list of medicines to first line except where there are specific health conditions where nurses have a
primary role, e.g. sexual health, rheumatic fever prophylaxis. The Council has also incorporated a specific requirement within the education for nurse prescribers on antibiotic resistance.

The Council notes that according to the analysis by Thomas et al. (2014) the prescribing of antibiotics in New Zealand increased by 43% during the seven years from 2005-2012. Strategies they identify to decrease antimicrobial consumption are guidelines and feedback to prescribers, improved immunisation uptake, educational strategies that target medical practitioners and their patients, and “delayed dispensing”. These strategies are also appropriate for registered nurse prescribers.

The Council is aware of possible communal harm resulting from prescribing medicines with a potential for abuse and misuse. The Council has incorporated a specific requirement within the education programme for nurse prescribers on drugs of dependence and misuse.

f. Any implications for remuneration: e.g. salary of prescriber;

The Council does not have a role in determining remuneration for nurses. The decision to increase a nurse’s salary based on role and responsibility is made by the employer. Nursing organisations have indicated to the Council that they do not want an additional scope of practice or a title like “specialist” nurse because it creates confusion with employment titles and may increase nurse prescribers’ expectations of remuneration. Some nurses who have become diabetes registered nurse prescribers employed by DHBs would be remunerated on the Designated Senior Nurse and Midwifery Salary scales at Grades 4 and 5 ($80-90K approximately). These roles (clinical nurse specialist/specialist nurse) are significantly better remunerated than DHB community nurse (between $54,657 (after three years) and $70,844) (NZNO, 2012a). In primary health, registered nurses are paid merit point 2 (a maximum of $64,067 after five years’ experience) if they meet the following: “Consistently high involvement in clinical management of acute/chronic illness, e.g. asthma, diabetes, hypertension, anticoagulation, Care Plus. This may include the running of acute/chronic illness or well person orientated clinics, e.g. in industry or school settings, regular and significant contribution to education of other staff or patient groups. This may occur in either a clinic or community setting” OR “Significant additional workplace income generation either through charging for services, or significantly contributing to the securing of additional contracts such as additional ACC or PHO service contracts” (NZNO, 2012b).

g. Any compliance costs, including safe handling procedures and data management;

Most of the medicines do not have any additional compliance costs except for vaccines that have a cold chain requirement. As many nurses are already in health teams as authorised vaccinators this is viewed as an existing cost with no change expected.

Some medicines are available on Practitioner Supply Order. As nurses are required to work in a health team the compliance costs related to bulk supply and storage are also viewed as an existing cost with no change expected.
6. Prescribing parameters

h. scope of practice;

Registered nurses wishing to practise in New Zealand must be registered with the Council and hold a current practising certificate. Under the HPCA Act the Council has gazetted the following scope of practice:

*Registered nurse scope of practice*

Registered nurses utilise nursing knowledge and complex nursing judgment to assess health needs and provide care, and to advise and support people to manage their health. They practise independently and in collaboration with other health professionals, perform general nursing functions and delegate to and direct enrolled nurses, health care assistants and others. They provide comprehensive assessments to develop, implement, and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making. This occurs in a range of settings in partnership with individuals, families, whānau and communities. Registered nurses may practise in a variety of clinical contexts depending on their educational preparation and practice experience. Registered nurses may also use this expertise to manage, teach, evaluate and research nursing practice. Registered nurses are accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards. There will be conditions placed in the scope of practice of some registered nurses according to their qualifications or experience limiting them to a specific area of practice.

The Council will include additional wording in the scope of practice to indicate that some nurses with additional experience and education may prescribe if authorised by the Council. The Council will confirm the specific wording when the community nurse prescribing proposal is more developed but consulted on the following:

*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.*

The Council will add an additional prescribed qualification to the scope of practice for registered nurses who choose to prescribe. This will be a postgraduate diploma in registered nurse prescribing for long-term and common conditions.

i. client/age group;

Nursing has a broad scope of practice so restricting the proposal to specific client/age groups is not the intention of the proposal. The Council is aware of specific guidance that is already available on prescribing for children through the New Zealand Children’s Formulary. The postgraduate diploma content includes consideration of client variable including age with respect to pharmacology.
j. **disease states, client setting;**

This proposal is specifically focused on prescribing for long-term and common conditions within primary health care and outpatient settings including general practice, specialist outpatient clinics, family planning, sexual health, public health, district and home care, and rural and remote areas.

Specific conditions include diabetes and related conditions, hypertension, respiratory diseases including asthma and COPD, anxiety, depression, heart failure, gout, palliative care, contraception, vaccines, common skin conditions and infections.

The registered nurse will determine the medicines and conditions she/he will prescribe based on her/his specific area of practice. Attempts were made to introduce nurse prescribing by developing lists and regulations for specialty areas in 2001. It was concluded that “the current method of regulating nurse prescribing by detailing a list of medicines for each specific area of practice is extremely cumbersome and proved unworkable. Nurses practice in a wide range of areas. The regulation of a full schedule for each of these areas is unworkable” (Ministry of Health, 2005).

The Council believes nurses will be educated to understand their accountabilities as prescribers and to determine her/his competence to prescribe a particular medicine.

A small number of medicines will be restricted to nurses practising in specific specialty services i.e. addictions and ophthalmology.

k. **how independent prescribing will sit with other collaborative arrangements, e.g. for continuity of care**

Although registered nurses will be able to make independent prescribing decisions, they will be required to have a collaborative working relationship with a health care team that includes an authorised prescriber a medical or nurse practitioner with whom they can readily consult.

The Council has adopted the Institute of Medicine definition of team-based care:

> “the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers – to the extent preferred by each patient – to accomplish shared goals within and across settings to achieve coordinated, high-quality care” (Mitchell et al., 2012)

and the College of Registered Nurses of British Columbia definition of collaboration:

> “joint communication and decision-making with the expressed goal of working together toward identified health outcomes while respecting the unique qualities and abilities of each member of the group or team” (College of Registered Nurses of British Columbia, 2014).

The Council intends to further develop its guidance for registered nurse prescribers before this
application is implemented. It will build on the *Guidance documents for Diabetes Registered Nurse Prescribers* (see Appendix 5) and include a definition of supervision and requirements for ongoing mentorship and case review as part of good practice.

The *Competencies for nurse prescribers* (outlined in Appendix 4) require collaboration and communication with the patient’s primary care provider.

The specific competencies are:

**Competency Area 3: Communicates the treatment plan clearly to other health professionals.**

**Element 3.1 Develops and maintains effective relationships, and communicates effectively with patients, carers, other prescribers and members of the multidisciplinary health care team.**

3.1.1 Provides clear instructions to other health professionals who dispense, supply or administer medicines prescribed for the client.

3.1.2 Prepares prescriptions or medication orders that comply with relevant legislation, guidelines or codes of practice, and organisational policies and procedures.

3.1.3 Collaborates and engages in open, interactive discussions with other health professionals caring for the client.

**Element 3.2 Provides information about medicines and the treatment plan with the client’s consent to other health professionals who provide care to the client.**

3.2.1 Provides information about the treatment plan to members of multidisciplinary health care teams involved with their care.

And

2.1.13. Refers the client for further assessment or treatment when the suitable treatment options are outside the nurse’s own scope of practice.

5.2.3 Demonstrates respect for the scope of practice of other health professionals and their contribution within a collaborative team, particularly that of the client’s main health care provider.

I. **how it fits with models of care, integrated services and patient-centred care;**

This proposal fits with and enhances existing models of care for chronic disease and long-term condition management and the extension of nursing roles and scope of practice. It aligns with the development of specialty nurse roles in the care and clinical management of people with long-term and common conditions.

Integrated care requires services to work more closely together for the benefit of the patient. This model requires a collaborative team approach, and collaboration and communication with others involved in the care of the patient.

The proposal allows patients more choice about who delivers their care. The competencies require the nurse to share decision making with the patient. This proposal also enables more
choice and improved access for frail and housebound patients and the ‘hard to reach’ with long-term conditions (Carey et al., 2014).

m. how scope of practice differentiates from associated disciplines;

The registered nurse prescriber will have a narrower scope of prescribing practice than that of a medical practitioner or nurse practitioner. Registered nurses will seek advice or refer patients who are outside their level of competence. Nurses will prescribe in situations where the diagnosis has already been made, or diagnosis is relatively uncomplicated or builds on an identified underlying disease process, or for minor ailments or illnesses. Diagnostic uncertainty can be discussed with an authorised prescriber.

7. Classes of medicines

Commonly used medicines for common conditions

The medicines list has been developed from the New Zealand Formulary and the Community Pharmaceutical Schedule. The list contains commonly used medicines for common conditions and is not an inclusive list. The list was originally developed by considering the common therapeutic areas in which primary health and specialty nurses might prescribe based on UK reports (Latter et al., 2011 and Hacking & Taylor, 2010) on nurse and pharmacist prescribing, and the medicines identified under these therapeutic areas in the Community Pharmaceutical Schedule.

Funded medicines

Patient access to subsidised medicines was a key consideration of the proposal so medicines that are not presently funded have, in most cases, been excluded from the list. PHARMAC has indicated it would consider nurse prescribers being able to repeat prescribe “Special Authority” medicines so some of these medicines have been recommended to be included.

Other PHARMAC mechanisms such as “specialist only” and “retail pharmacy specialist” have led to some medicines being removed. Best practice guidelines from the New Zealand Formulary, NICE (National Institute for Health and Care Excellence) and BPAC (Best Practice Advocacy Centre) have been consulted and have influenced the list.

The decisions were made to create a list that is appropriate for now with the understanding that the prescription medicines list can be modified more easily (through gazette notices) in the future as new medicines are funded and/or existing medicines are no longer recommended or superseded.

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11 Special Authority is an application process in which a prescriber requests government subsidy on a Community Pharmaceutical for a particular person (http://www.health.govt.nz/new-zealand-health-system/claims-provider-payments-and-entitlements/special-authority)
Greater specificity in the medicines list

The Council received considerable feedback on the medicines list during the consultation. Some of this related to the listing of ingredients in the list and some concerns were based on unspecified routes of administration. Health Legal (Ministry of Health) has advised the Council that the list does not have to conform exactly to the language of the Medicines Regulations. Community pharmaceutical names, combinations and restrictions related to route, context and continuation prescribing\(^{12}\) have been included to provide greater clarity about the specific form of the medicine and the circumstances under which it can be prescribed.

This analysis and specification has led to some medicines being removed from the prescription medicines list as the form or route changed their classification to restricted (pharmacist only), pharmacy only or general sales. The Council has received assurance from Ministry of Health staff that nurse prescribers will be able to prescribe these medicines although they are not prescription medicines. PHARMAC has also assured the Council that it would subsidise these medicines for nurse prescribers (Appendix 10). See further discussion later in this section under non-prescription medicines.

Antibiotic resistance

Antibiotic stewardship and best practice guidelines have been followed and antibiotics have been removed if they require a specialist recommendation. Some antibiotics have been added to allow nurse prescribers to select a narrow spectrum treatment instead of a broad spectrum agent or to have a choice if a patient is allergic to penicillins. Emphasis has been included in the prescribing education programme standards.

Unapproved medicines and unapproved uses of medicines

Unapproved medicines are not permitted to be dispensed by a pharmacist except when prescribed by a medical practitioner or dentist under section 29 of the Medicines Act and have not been included in the lists. Other medicines that would be prescribed for unapproved uses or for unapproved patient groups under section 25 of the Medicines Act have generally been removed. Where there is clear evidence that the medicine is widely used for this indication and its use is supported by evidence it is included on the list.

Other considerations

Other submitters were concerned about high-risk medicines or those with complex diagnostic or close monitoring requirements. In many cases these medicines have been removed. Please refer to the Medicines Report in Appendix 7 for classes and individual medicines not included after consideration of submitter comments or for other reasons. The Council has taken a

\(^{12}\) The Council has indicated “continuation prescribing” for a small number of medicines where the prescribing decision is specialised. The Council has used this term to avoid confusion as “repeat prescribing” is often used to describe a process in primary care where a medical practitioner signs a script for a patient based on a previous consultation without seeing the patient again.
conservative approach to the medicines list. The Council believes that the therapeutic areas covered by this list might increase over time as confidence grows in the prescribing ability of registered nurses practicing in primary health and specialty teams.

The Council considered a submitted list of medicines for neonatal units but believed many of these medicines were not appropriate for registered nurses to prescribe. Some of these medicines were unapproved or unapproved for this age group, or the diagnostic and prescribing decisions involved were considered to be outside scope of practice. Neonatal units also do not fall within the parameters of the proposal, which is focused on access to medicines for patients in outpatients and the community. The Council considered that patients in neonatal units should have access to medicines through authorised prescribers (medical practitioners or nurse practitioners) or standing orders. The Council concluded it will require evidence of interdisciplinary collaboration as well as safety and efficacy before further therapeutic areas or medicines are added to the list.

**Prescription medicines**

An indicative list of prescription medicines can be found in classes based on the New Zealand Formulary therapeutic headings can be found in Appendix 6. Funding barriers are also identified in this table. The medicines included on the list relate to conditions already discussed in this proposal, i.e. cardiovascular disease, diabetes, respiratory disease, infections, depression, gout, skin conditions and minor ailments. The profession needs to be able to prescribe all medicines that are funded. In some situations patients may pay for unfunded medicines, e.g. travel medicines and vaccines, or employers may pay, e.g. influenza vaccine. Please note that immunoglobulins and travel medicines were requested by the Defence Force. Some of the vaccines requested by Defence are unavailable or unapproved in New Zealand. The Council has suggested that vaccines and immunoglobulins are listed as classes as are insulins.

As this list is not inclusive or based on exclusions, but based on common medicines the Council has not identified other medicines that fall inside all of the broad classes of medicines listed. Further information on some classes and individual medicines excluded from the scope of practice can be found in the *Medicines Report* in Appendix 7.

**Controlled drugs list**

A detailed report on the controlled drugs list, including the responses from submitters and the Council response, can be found in the *Medicines Report* Appendix 7. The Council’s rationale for including some drugs and excluding others is explained. The Council is aware this list would be set by regulation under the *Misuse of Drugs Act 1975* and does not have the potential to be changed easily. For this reason medicines that can be prescribed as opioid substitutes are included although there is a legislative barrier to non-medical prescribers at the present time. Some of the medicines on this list are also discussed in the mental health section of the *Medicines report*. 
The Council also considered the response from submitters to its questions about the restrictions on the prescribing of opioids by designated nurse prescribers in the Misuse of Drugs Regulations 1977. The Council recommends to the Ministry of Health that the restrictions are changed to:

1) a requirement to be working in a collaborative prescribing team; and
2) limited to a seven day supply after which there must be consultation with an authorised prescriber.

The list of controlled drugs can be found overleaf.

---

13 No designated prescriber nurse may (within the authority given by regulation 12A(1)(a)) give a prescription for the supply of a controlled drug—
   (a) otherwise than for the treatment of a patient under the designated prescriber nurse’s care; and
   (b) in circumstances that are not cases of emergency; and
   (c) in any quantity greater than the quantity reasonably required for the treatment of the patient for a period of 3 days. (Misuse of Drugs Regulations 21(4)).
### Table 1: List of controlled drugs

<table>
<thead>
<tr>
<th>Class</th>
<th>Controlled drug</th>
<th>Requirements as to use, route of administration or pharmaceutical form</th>
<th>Funding barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazepines</td>
<td>alprazolam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>diazepam</td>
<td>Continuation prescribing; oral only</td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>lorazepam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>lormetazepam</td>
<td></td>
<td>Part subsidy</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>nitrazepam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>oxazepam</td>
<td>Continuation prescribing</td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>temazepam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>triazolam</td>
<td></td>
<td>Part subsidy</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>clonazepam</td>
<td>For anxiety and panic disorder only</td>
<td></td>
</tr>
<tr>
<td>Hypnotics</td>
<td>zopiclone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opioid analgesics</td>
<td>buprenorphine</td>
<td>Transdermal only</td>
<td>Not subsidised</td>
</tr>
<tr>
<td>Opioid analgesics</td>
<td>buprenorphine with naloxone</td>
<td>Continuation prescribing; Sublingual only</td>
<td></td>
</tr>
<tr>
<td>Opioid analgesics</td>
<td>dihydrocodeine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opioid analgesics</td>
<td>codeine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opioid analgesics</td>
<td>fentanyl</td>
<td>Transdermal only</td>
<td></td>
</tr>
<tr>
<td>Opioid analgesics</td>
<td>methadone</td>
<td>Continuation prescribing; oral only</td>
<td></td>
</tr>
<tr>
<td>Opioid analgesics</td>
<td>morphine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Specialist ophthalmology medicines list

The Council considered submissions on the addition of ophthalmology medicines. This report can be found in Appendix 7. There appears to be patient need, multidisciplinary support and a collaborative framework for this prescribing. It also falls within the Council’s proposal of enabling specialist nurses in ambulatory services to prescribe for long-term and common conditions. The Council believes these medicines should be restricted to nurses practising in ophthalmology specialist services because of the specific equipment and skills required for diagnosis. In some cases continuation prescribing is appropriate, e.g. glaucoma. The medicines on this list were
not included in the Council’s consultation process. The Council does not wish this to be a factor in delaying the progression of this proposal and would accept that this list be added at a later time if further consultation is required. The Council has submitted a separate list of prescription medicines for nurses working in specialist ophthalmology teams (see the table below).

Table 2: Specialist ophthalmology medicines list

<table>
<thead>
<tr>
<th>Class</th>
<th>Medicine</th>
<th>Requirements as to use, route of administration or pharmaceutical form</th>
<th>Funding barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antimuscarinics</td>
<td>tropicamide</td>
<td>Specialist ophthalmology teams</td>
<td></td>
</tr>
<tr>
<td>Antimuscarinics</td>
<td>cyclopentolate hydrochloride</td>
<td>Specialist ophthalmology teams</td>
<td></td>
</tr>
<tr>
<td>Antimuscarinics</td>
<td>atropine</td>
<td>Specialist ophthalmology teams</td>
<td></td>
</tr>
<tr>
<td>Antibiotics</td>
<td>fucidic acid</td>
<td>Specialist ophthalmology teams</td>
<td></td>
</tr>
<tr>
<td>Corticosteroids</td>
<td>fluorometholone</td>
<td>Continuation prescribing-specialist ophthalmology teams</td>
<td></td>
</tr>
<tr>
<td>Corticosteroids</td>
<td>prednisolone acetate</td>
<td>Continuation prescribing-specialist ophthalmology teams</td>
<td></td>
</tr>
<tr>
<td>Corticosteroids</td>
<td>dexamethasone</td>
<td>Continuation prescribing-specialist ophthalmology teams</td>
<td></td>
</tr>
<tr>
<td>Corticosteroids (with antibacterials)</td>
<td>dexamethasone + neomycin sulfate + polymyxin B sulphate</td>
<td>Continuation prescribing-specialist ophthalmology teams</td>
<td></td>
</tr>
<tr>
<td>Local anaesthetics</td>
<td>oxybuprocaine (benoxinate) hydrochloride</td>
<td>Specialist ophthalmology teams</td>
<td>Hospital only</td>
</tr>
<tr>
<td>Local anaesthetics</td>
<td>proxymetacaine hydrochloride</td>
<td>Specialist ophthalmology teams</td>
<td>Hospital only</td>
</tr>
<tr>
<td>Local anaesthetics</td>
<td>tetracaine (amethocaine) hydrochloride</td>
<td>Specialist ophthalmology teams</td>
<td>Hospital only</td>
</tr>
<tr>
<td>Local anaesthetics</td>
<td>Fluorescein sodium with lignocaine (eyedrop)</td>
<td>Specialist ophthalmology teams</td>
<td>Hospital only</td>
</tr>
<tr>
<td>Treatment of glaucoma-Carbonic anhydrase inhibitors</td>
<td>brinzolamide</td>
<td>Continuation prescribing-specialist ophthalmology teams</td>
<td></td>
</tr>
<tr>
<td>Treatment of glaucoma-Carbonic anhydrase inhibitors</td>
<td>dorzolamide</td>
<td>Continuation prescribing-specialist ophthalmology teams</td>
<td>Partial subsidy</td>
</tr>
<tr>
<td>Treatment of glaucoma-Beta-blockers compound preparations</td>
<td>brimonidine + timolol</td>
<td>Continuation prescribing-specialist ophthalmology teams</td>
<td></td>
</tr>
</tbody>
</table>

24
<table>
<thead>
<tr>
<th>Class</th>
<th>Medicine</th>
<th>Requirements as to use, route of administration or pharmaceutical form</th>
<th>Funding barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of glaucoma-Miotics</td>
<td>pilocarpine</td>
<td>Continuation prescribing-specialist ophthalmology teams</td>
<td></td>
</tr>
<tr>
<td>Treatment of glaucoma-Beta-blockers</td>
<td>timolol</td>
<td>Continuation prescribing-specialist ophthalmology teams</td>
<td></td>
</tr>
<tr>
<td>Treatment of glaucoma-Prostaglandin analogues</td>
<td>latanoprost</td>
<td>Continuation prescribing-specialist ophthalmology teams</td>
<td></td>
</tr>
<tr>
<td>Treatment of glaucoma-Prostaglandin analogues</td>
<td>travoprost</td>
<td>Continuation prescribing-specialist ophthalmology teams</td>
<td></td>
</tr>
<tr>
<td>Treatment of glaucoma-Prostaglandin analogues</td>
<td>bimatoprost</td>
<td>Continuation prescribing-specialist ophthalmology teams</td>
<td></td>
</tr>
<tr>
<td>Antivirals</td>
<td>aciclovir</td>
<td>Continuation prescribing-specialist ophthalmology teams</td>
<td></td>
</tr>
</tbody>
</table>

**Non-prescription subsidised medicines list**

A list of non-prescription medicines can be found in Appendix 8. This list covers many minor ailments that nurses can also safely prescribe for and includes many topical medicines. This list was consulted on and has been prepared for submission to PHARMAC for consideration of subsidies for the patients of registered nurse prescribers. The medicines are named according to the PHARMAC Community Pharmaceutical Schedule and brands are included. The Council has had confirmation from PHARMAC that it would take a similar approach to that for pharmacist prescribers where subsidised prescriptions for restricted (pharmacist only), pharmacy only and general sales items within the Community Pharmaceutical Schedule. PHARMAC have suggested the Council confirm with the Ministry of Health that there are no barriers to designated nurse prescribers writing prescriptions for restricted or pharmacist only medicines. The Council has had some verbal assurance there are no barriers and has proceeded based on this. It is not clear if the Council would need to keep a list of non-prescription items now that the New Zealand Formulary contains that information. A list of devices for PHARMAC consideration is also included.

**Non-prescription non-subsidised medicines list**

The review of the list identified some non-prescription forms of medicines that nurses may wish to “prescribe” but they are not subsidised. The Council has included this list for completeness. See Table 6 of the *Medicines Report* for medicines that fall into both categories but are unsubsidised.
PHARMAC suggested that the Council identify non-subsidised, non-prescription medicines that nurses might “prescribe”. The Council has done this to a limited extent where the items were identified on the original prescription or non-prescription lists. A number of non-prescription medicines were requested to be added to the lists (e.g. lubricants) for Ophthalmology. There are also items that are not subsidised in the community but are only available in hospitals on this list. The Council is not convinced that it is appropriate for it to maintain a list of non prescription non subsidised items for nurse prescribers. Theoretically this list could be extremely large and duplicates other sources of information about medicines that are currently available. The Council notes that the new version of the New Zealand Formulary now contains information on Medicines Classifications so nurse prescribers could consult this instead if they wished to “prescribe” an unsubsidised non prescription item. The list is included in Appendix 9.

8. Competencies and education

Registered nurses develop the skills and knowledge for prescribing through education and experience. Undergraduate education prepares nurses to work with a range of patients and to assess and make clinical decisions related to nursing practice. This forms a basis for experienced nurses to then develop advanced skills and knowledge in assessment, decision making, clinical management, and prescribing in a specialty area.

Undergraduate education

Registered nurses have a broad scope of practice and work with patients with many health conditions across a variety of health settings. For this reason undergraduate programmes¹⁴ include the following standards:

2.2 The programme specifically requires students to demonstrate, in practice at a graduate level, the following:
- pharmacology knowledge and medicine management
- comprehensive health consumer assessment skills and clinical decision making skills
- therapeutic communication with health consumers
- working within a health care team; providing direction and delegation in practice
- the use of information technology and health information management.

2.12 The clinical experiences occur in a range of settings with health consumers across the lifespan and must include:
- primary health care and community settings
- acute care including medical and surgical settings
- continuing care settings including rehabilitation/disability care settings
- mental health care including acute and rehabilitation/continuing care settings.

Clinical experience before learning to prescribe

The Council has specified that registered nurses must complete three years of practice in the specialty they intend to prescribe before they may commence a prescribing practicum. This

¹⁴ Education programme standards for the registered nurse scope of practice July 2010
acknowledges that nurses gain further understanding of patient conditions, clinical management, and pharmacology and prescribing practices through practice experience. Lim et al (2014)\textsuperscript{15} found that for nurses who studied postgraduate pharmacology, practice experience facilitated their learning and they were able to apply new knowledge to their work immediately.

**Postgraduate diploma in registered nurse prescribing for long-term and common conditions**

Under the HPCA Act, the Council is the authority responsible for the registration of nurses. In accordance with section 12 of the Act, the Council prescribes qualifications for scopes of practice. In addition the Act requires the Council to accredit these qualifications and monitor any New Zealand tertiary education provider providing such an accredited qualification.

The *Postgraduate diploma in registered nurse prescribing for long-term and common conditions* will be an additional prescribed qualification for the registered nurse scope of practice for nurses who choose to apply for this prescribing authority.

The provision of the *Postgraduate diploma in registered nurse prescribing for long-term and common conditions* programmes will be limited to tertiary education providers also providing Council-accredited programmes which lead to registration as a nurse practitioner. This is because this qualification may, in the future, become a prerequisite for the nurse practitioner master’s degree programmes. (At present nurse practitioners must complete a 240credit clinical master’s degree. The postgraduate diploma may create a staircase for some nurses who choose to complete another 120 credits to become a nurse practitioner. The Council has not yet consulted on this educational pathway for nurse practitioners but intends to this year.)

Upon award of the qualification, graduates will be eligible to apply to the Council for an authorisation/condition to be included in their scope of practice enabling them to prescribe for long-term and common conditions when a regulation under the Medicines Act 1981 comes into effect.

In setting qualifications the Council must balance public safety with requirements for prescribing that are not too onerous, costly or restrictive (section 13, HPCA Act).

The Council carefully considered whether the requirements for diabetes registered nurse prescribers were appropriate for broader registered nurse prescribing authority. Diabetes registered nurse prescribers must demonstrate the following:

\begin{itemize}
  \item[a)] the completion of two level eight papers or equivalent as assessed by the Nursing Council. The papers must include the following content: pathophysiology, clinical assessment and decision making, and pharmacology; and
\end{itemize}

b) a clear understanding of diabetes disease processes at level eight or equivalent as
determined by the Nursing Council; and

c) the completion of a six-to-12-week practicum with the medical practitioner supervising
the prescribing, which demonstrates knowledge to safely prescribe all specified
diabetes medicines and knowledge of the regulatory framework for prescribing.

The diabetes nurse prescribing demonstration project evaluation report (Wilkinson et al., 2011)
recommended a postgraduate diploma with a six-to-12-week practicum with an authorised
prescriber to prepare nurses for first-time prescribing. The Council considered the feedback
within the evaluation report which indicated a high need for supervision during the six -12-week
prescribing practicum. The medical supervisors already had heavy workloads and some
suggested it would have been easier if the nurses were better prepared (i.e. were better and
recently educated in pharmacology). The nurses in the demonstration project thought a
combination of experience and postgraduate education was needed to safely prescribe. More
confidence was expressed about the diabetes nurses’ readiness to prescribe at sites where the
nurses had higher qualifications.

The Council was also advised by the Ministry of Health that ongoing supervision of the
prescriber, as in the diabetes model, did not fit with the designated class of prescribers.

An evaluation of nurse and pharmacist prescribing in the UK (Latter et al, 2010, p187) suggests
the lack of assessment and diagnostic skills before a prescribing course is undertaken means
some prescribers are not being adequately prepared and have limited ability to prescribe for
patients with co-morbidities.\textsuperscript{16}

The Council, after considering the diabetes nurse prescribing project, the requirements of
designated prescriber, and the UK findings, consulted on a more robust qualification for
registered nurse prescribing in primary health and specialty teams.

**Curriculum**

The postgraduate programme is equivalent to 1200 hours of study including 120 credits.\textsuperscript{17} A
graduate of the postgraduate diploma must show evidence of advanced knowledge of
pathophysiology, pharmacology, assessment and diagnostic reasoning in relation to the
clinical management of and prescribing for patients with long-term and common conditions in
New Zealand. The programme must include a prescribing praxis\textsuperscript{18} with a prescribing
practicum component (i.e. period of learning in practice).

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\textsuperscript{16} In the UK nurses are required to complete a 26-week prescribing course. Assessment and diagnostic
skills are signed off by their employer before they commence the course.

\textsuperscript{17} The postgraduate diploma requires a minimum of 120 credits from levels 7 and above, with a minimum

\textsuperscript{18} The prescribing praxis is to include content on the legal, regulatory, ethical and policy framework for
prescribing in New Zealand.
Programme content

Following the successful completion of the programme, the registered nurse will be able to:

- demonstrate advanced knowledge of scientific concepts and common pathophysiological processes
- understand the underlying principles of pathophysiology and clinical management of long-term and common conditions, e.g. cardiovascular disease, diabetes and related conditions, respiratory disease, common infections, anxiety and depression.
- critically analyse and interpret research-based knowledge regarding pathological changes in selected disease states
- apply client assessment skills and diagnostic reasoning at an advanced level in their practice within their scope of practice
- critically analyse clinical assessment findings, in relation to underlying pathophysiological processes. Analyse and generate solutions to clinical problems
- articulate advanced knowledge of client assessment and diagnostic reasoning to formulate a list of differential diagnoses or a diagnostic decision.
- demonstrate knowledge of principles of pharmacokinetics and pharmacodynamics, and apply these to client variables (such as age and disease state)
- critically analyse pharmacotherapeutic indications for common classes of drugs for long-term and common conditions
- critically evaluate the causes of antimicrobial resistance and the importance of incorporating non-pharmacological strategies and knowledge of local resistance patterns into prescribing practice
- demonstrate the ability to identify contraindications, effects and drug interactions associated with the use of prescription, over-the-counter and complementary medicines and devices
- demonstrate the ability to recognise situations of drug misuse and drug seeking, and take appropriate action
- demonstrate the ability to perform a comprehensive medicines assessment and to make safe prescribing decisions within professional and regulatory frameworks.

2.11 Prescribing practicum

2.11.1 The prescribing practicum (included in the prescribing praxis paper) must be the final component of the programme.
2.11.2 The prescribing practicum component of the programme must consist of at least 150 hours of clinical practice under the supervision of an appointed designated authorised prescriber (DAP) in a collaborative health team environment. It will include opportunities to develop diagnostic skills, patient consultation and assessment skills, clinical decision-making and assessment skills, and monitoring skills.

2.11.3 There is a process to ensure the final assessment against the Council’s Competencies for nurse prescribing will be undertaken collaboratively between the DAP in the clinical practice and academic staff.

1.1. Entry requirements for the prescribing practicum

The registered nurse is required to:

- hold a current practising certificate and must have completed three years’ equivalent full-time practice in the area of practice she/he will be prescribing

- have a collaborative working relationship with a multidisciplinary team and have the support of a designated authorised prescriber (DAP) (a vocationally registered medical practitioner or nurse practitioner) as a mentor who will support her/him to prescribe

- undertake the practicum in an organisation that supports nurse prescribing through policy, audit, peer review and accessibility of continuing education

- have identified and have access to an area of clinical practice in which to develop their prescribing skills and have up-to-date clinical knowledge relevant to their intended area of prescribing practice.

Funding and resource implications

The Postgraduate diploma in registered nurse prescribing for long-term and common conditions builds on existing programmes within the Master of Nursing (Clinical). It is not anticipated new funding would be required as these programmes are already provided by tertiary educators and supported by employers and Health Workforce New Zealand (HWNZ). To encourage nurse prescribers in primary health, particularly in rural and remote areas, some additional support may be needed to facilitate release time and/or the prescribing practicum.

The investment in education by employers and HWNZ will contribute to improved patient care and to developing a nursing workforce that will be needed in the future when an ageing population causes health demands to increase. HWNZ presently funds nurses to complete postgraduate education. The Council recognises this funding may be redirected towards the postgraduate diploma in registered nurse prescribing and therefore believes it is important that
local support is in place before nurses commence these programmes so the investment is realised for the benefit of New Zealanders.

The proposed standards for the postgraduate programmes can be found in Appendix 3.

**Competencies**

The proposed competencies for nurse prescribers have been adapted from the National Prescribing Service in Australia\(^\text{19}\) and can be found in Appendix 4. The seven competency areas have been condensed to five as there was some overlap with the existing competencies for registered nurses, i.e. the registered nurse competencies already have requirements for working in partnership with health consumers, and communicating and collaborating with other health professionals.

9. Consultation

The Council began consulting with relevant groups in February 2012 before it developed its proposal. The specific groups it has met with are identified below.

a. own professional groups;

The Council has met regularly (three-four times a year) with representatives of all NNOs to discuss the progress of this proposal. The NNOs are professional groups which represent nurses including the New Zealand Nurses Organisation, the College of Nurses Aotearoa, Te Ao Māramatanga (New Zealand College of Mental Health Nurses), the Council of Deans of Nursing, Nurse Educators in the Tertiary Sector, District Health Board Directors of Nursing, Nurse Executives of New Zealand and. Te Kaunihera O Nga Neehi Māori O Aotearoa (National Council of Māori Nurses).

In addition the Council has met with other national nursing groups to discuss or inform them of the Council’s proposals. These include the General Practice NZ Nurse Leaders Forum, the National PDRP Coordinators, NENZ national meetings, the MOH Primary Nurses Reference Group, Home care senior nurses and Nurse Practitioners New Zealand (NPNZ). The Council has also presented on the proposals to nurses at Compass Health, HVDHB, CCDHB, Lakes DHB and West Coast DHB, and at the National Conference of the College of Primary Health Care Nurses (NZNO) and the Rural General Practice Conference Nursing Forum.

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b. other relevant health professional groups (including medical and other prescribers);


c. health practitioner regulatory authorities;

The Council has met with the Medical Council of New Zealand and the Pharmacy Council of New Zealand.

d. pharmacy organisations;

The Council has met with the Pharmaceutical Society.

e. government organisations, e.g. Ministry of Health (Policy, National Health Board, Relevant work areas, e.g. Nursing, mental health, etc. /Medsafe);

The Council has met regularly with Chief Nurses Office, HWNZ, Health Legal and Health Policy, and also met with Chief Medical Advisor, Medsafe, the Director of Public health and Immunisation team, Cathy O’Malley, Deputy Director-General, Sector Capability and Implementation, Ministry of Health.

f. funding authorities (e.g. PHARMAC);

The Council has met with PHARMAC.

g. other interested organisations including DHBs and PHOs.

The Council has met with Family Planning and the General Practice Leadership Forum.

In 2013 the Council completed a formal consultation process. The consultation document (see Appendix 1) was emailed to over 500 stakeholders including the organisation types identified above and Maori and Pacific health providers and consumer groups (see Appendix 11 for the Consultation email and List of organisations consulted). The Council received 197 submissions that represented the views of a wide range of stakeholders including nurses, nurse practitioners, nursing organisations, medical organisations, pharmacist organisations, regulatory authorities and PHARMAC (please see Appendix 12 for the List of submitters).

The results of the consultation and how points raised have been responded to.

Please note that the Analysis of submissions (Appendix 2) contains information on the responses to both proposals. The main themes from the responses to the ‘specialist nurse
prescribing proposal' and the Council’s response are discussed below. Please note that the proposal has been renamed ‘Designated prescriber: Registered nurses practising in primary health and specialty teams’ but was titled ‘Specialist nurse prescribing’. The reasons for the change are discussed below under ‘Title’.

**Support for the Specialist nurse prescribing 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.

*Patient safety and fragmentation of care*

A small number of submitters were concerned about patient safety, misdiagnosis, inappropriate prescribing by nurses and fragmentation of care.

The Council has responded to these concerns by increasing the years of experience in a specialty before commencing the prescribing practicum from one year to three years, modifying the list of medicines that registered nurses can prescribe, and strengthening requirements for education, supervision, collaboration with an authorised prescriber and continuing competence as outlined in previous sections and below. The *Competencies for nurse prescribers* (Appendix 4) require the prescriber to make appropriate diagnostic decisions, prescribe appropriately with consideration for both communal and individual harm, and to communicate with other health professionals involved in the patient’s care.

*Delegated prescribing*

Some medical and pharmacist groups would prefer to see a model of delegated prescribing. The Council carefully considered these submissions but decided the prescribing authority would be too restrictive, would not maximise benefits for patients and was not supported by the nursing profession or all medical professionals. Some medical groups gave qualified support to specialist nurse prescribing under designated prescriber. These included the Royal Australasian College of Physicians, the Royal New Zealand College of General Practitioners and the Council of Medical Colleges.

**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 specialty to the title or to use registered nurse prescriber level 2.
The Council considered all feedback and decided to change the title of the proposal to *Designated prescriber: Registered nurses practising in primary health and specialty teams*. The Council believes this title describes the areas where nurses will be prescribing and the requirement to work as part of a collaborative team.

**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. Definitions of collaboration and team-based care adopted by the Council are included in section 6k.

Most submitters (91.6%) agreed that nurses with specialist nurse prescribing authority should be required to practise under supervision but the length of time for supervision varied from three months, to six months, to one year, to forever. Some submitters wanted flexibility with supervision timeframes, depending on the capability, and confidence of the nurse and supervisor. Some thought access to supervision may be variable and that making an absolutely defined timeframe may create unnecessary barriers. A few submitters suggested that supervision should include ongoing mentorship and monitoring of prescribing practice.

The issue of some health care providers requiring funding for supervision, as currently occurs for nurses undertaking a prescribing practicum, was raised by some as potentially problematic and a barrier. This was particularly an issue in primary care but may also be applicable in secondary care specialist services who have limited resources.

Some submitters asked for supervision to be more clearly defined. The Council will need to develop more guidance on how supervision should occur but as a first step has defined supervision as per the guidelines developed by the New Zealand Society for the Study of Diabetes, with doctors' accountabilities clearly defined.

*Supervision can be both formal and informal:*

*Formal supervision is regular protected time, specifically scheduled and kept free from interruptions, to enable facilitated in-depth reflection on clinical practice. Case review is a suggested mechanism for formal supervision to occur.*

*Informal supervision is the day to day communication and conversation providing advice, guidance or support as and when necessary.*

*Supervision is flexible:*

*Supervision is time limited and is flexible depending on the DRN’s requirements. Closer supervision is usually required in the beginning and decreases over time once the DRN and the doctor become confident with clinical reasoning and prescribing decisions.*
The experience from the diabetes nurse specialist prescribing projects in 2011 and 2012, where supervision occurred predominantly through opportunistic and planned regular retrospective case review, clearly showed that both nurses and doctors valued the supervision, with most describing it as mutually beneficial with reciprocal learning. The majority of the nurses in this study value the ongoing nature of their supervision relationship and many would not like to be prescribing without it.

Extending the requirement for a year would allow more time for the nurse to gain confidence and for the regular case review with both peers and the authorised prescriber to become an embedded part of practice. When considering practicalities for the Council, the nurse and the supervisor of removing the condition from scope of practice, it makes sense to link this condition to the nurse first presenting evidence of their continuing competence (as a prescriber) one year after they are first authorised.

Scope of practice or authorisation

A minority of submitters (38%) supported specialist nurse prescribers being registered in a new scope of practice. Most submitters (76.8%) agreed with the proposed wording to be added to the registered nurse scope of practice. Most submitters (62%) agreed with an authorisation/condition being included in the registered nurse scope of practice.

The Council considered the feedback and decided that prescribing authority would be through an authorisation/condition placed in the nurse’s scope of practice. This approach has been successfully trialled for diabetes registered nurse prescribers.

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 submitted that there needed 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 incorporate common mental health conditions in the programme.

The Council has made some changes to the standards and competencies for the postgraduate diploma to align it with the existing clinical master’s degree courses. The Council has incorporated recognition of prior learning standards into the programme standards and it will apply similar processes to nurses who have completed a qualification and applied to the Council. The ‘mentor’ definition has been broadened to include nurse practitioners and common mental health conditions are specified in the content of the programme.
The Council has also considered nurses who have gained prescribing rights to practice in diabetes health. Depending on the individual’s qualification and experience the Council would consider an application for broader prescribing rights or the existing authorisation/ condition could remain in place restricting them to prescribe in diabetes health under the supervision of a medical practitioner.

**Entry criteria**

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 prerequisite for entry to the programme.

The Council cannot restrict entry to tertiary education. However, it has applied entry requirements for the prescribing practicum which are in the last paper of the diploma. These are outlined on page 34. The clinical experience has been increased to three years in the prescribing specialty.

**Continuing competence requirements**

A strong majority of submitters (81.3%) agreed with the continuing competence requirements for specialist nurse prescribers. Some disagreed or stated that further details were required.

**Professional development**

Some submitters requested a specific number of hours, within the 60 hours already required for registered nurses, be related to prescribing.

The Council has decided that registered nurse prescribers are required to complete 20 prescribing-related hours of professional development out of the 60 required hours of professional development every three years. This may include education or formal updates on medicines or condition management, audit, peer review or formal mentoring by an authorised prescriber. These hours are to be verified by a senior nurse or employer.

**Prescribing practice**

The requirement for 60 days of prescribing practice over three years was considered insufficient by some whom felt prescribing was a skill that should be used in daily practice to remain proficient. A suggestion was made that 100-120 days was more appropriate to provide adequate exposure to prescribing decision making. In addition, some guidance as to how ‘prescribing practice’ was defined was requested.

The Council has increased the prescribing practice requirement for registered nurse prescribers to 40 days per year.
Prescribing practice is defined as “participation in patient consultations that include a comprehensive medicines assessment and consideration of the patient’s treatment plan including prescribed medicines. It will include the assessment, clinical decision making and monitoring skills outlined in the Competencies for nurse prescribers.”

Prescribing mentor

Guidance as to who was a suitable ‘prescribing mentor’ was sought by some submitters, with others considering nurse practitioners suitable to provide this function.

The Council has defined the prescribing mentor as “an authorised prescriber who works within the same multidisciplinary team as the specialist nurse with whom she/he can readily seek advice on diagnosis and prescribing as required”.

Frequency of monitoring

Eleven submitters suggested three-yearly monitoring was insufficient and more frequent monitoring was more appropriate. Suggestions ranged from one-yearly to every 18 months or two-yearly. Most of the 11 submitters supported one-yearly monitoring, forming part of the annual renewal of practising certificates. This occurs for the diabetes registered nurse prescribers and works well. The monitoring requirement was also annual for nurse practitioners until 2008 when it became three yearly.

The Council decided that registered nurse prescribers practising in primary health and specialty teams will be required to submit evidence annually when applying for their practising certificate that they have maintained their competence in prescribing. This includes a competence assessment or a letter of support from the prescribing mentor/supervisor.

Prescription medicines lists

Most submitters (62.3%) agreed with the list of prescription medicines for specialist nurse prescribing. Some submitters were concerned 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.

The Council’s response to feedback on the prescription lists has been to remove some medicines and to more clearly specify route and circumstances of some medicines. The Council has indicated “continuation prescribing”\textsuperscript{20} for a small number of medicines where the

\textsuperscript{20} This definition adapted from the College of Registered Nurses of British Columbia is used by the Council: “The doctor or nurse practitioner initiates the drug therapy and the registered nurse prescriber assumes responsibility and authority for the continuation of the drug therapy, including ongoing
prescribing decision is specialised. It has used this term to avoid confusion as “repeat prescribing” is often used to describe a process in primary care where a medical practitioner signs a script for a patient based on a previous consultation without seeing the patient again.

The Council has not developed specialty lists as there are many overlaps between specialties in long-term and common conditions, especially in primary health. For example, patients with diabetes in the Diabetes Nurse Specialist Prescribing Project had co-morbidities such as hypertension, dyslipidaemia, obesity, diabetic eye disease, renal disease, asthma/COPD, ischaemic heart disease and foot problems (Wilkinson et al., 2011, p23). These patients could also develop other conditions (e.g. anxiety and depression) or minor ailments from time to time. These medicines fall across a range of body systems and classifications.

The Council agrees that many ophthalmology medicines require specialty equipment and expertise, and should be restricted to nurses working in these teams.

Please refer to the medicines reports in Appendix 7 for further details of the comments made by the submitters and the Council’s decisions on individual medicines and classes of medicines.

**Non-prescription medicines list**

Nearly all submitters (98.2%) agreed that specialist nurse prescribers should be able to access the list of non-prescription medicines. The list is in Appendix 8. More discussion is included in section 6.

**Controlled drugs**

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. More details of the submitters’ comments and the Council’s response are included in Appendix 7 and discussed in section 7.

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assessment and monitoring, re-ordering and/or making adjustments to the drug therapy, and referral as needed.”
References


