Proposal for designated prescriber: registered nurses practising in community health

September 2016
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1 Executive summary

The Nursing Council of New Zealand (the Council) intends authorising registered nurses (registered nurses prescribing in community health) to prescribe under the Medicines (Designated Prescriber – Registered Nurses) Regulations 2016. The Council plans a managed introduction so it can evaluate this model in partnership with Counties Manukau District Health Board (Counties Manukau Health) and Family Planning New Zealand.

The Council consulted on this proposal in 2013. It will enhance the role that nurses have in health promotion, disease prevention and the assessment and treatment of minor ailments and illnesses. This prescribing authority would also allow suitably qualified registered nurses working in the community\(^1\) to treat common skin conditions (such as simple eczema, impetigo, fungal infections and parasites), ear infections, sore throats and provide rheumatic fever prophylaxis and ongoing treatment, pain relief for low level pain, contraception and treatment for common sexually transmitted infections, urinary tract infections and constipation.

This group of registered nurses would complete a Council-approved recertification programme provided by a national or regional health provider organisation. Clinical governance standards would support safe prescribing by linking registered nurses with collegial support and current best practice information. Registered nurses prescribing in community health would prescribe for normally healthy people using decision support tools (clinical pathways or guidelines).

They would be able to prescribe 32 prescription medicines and access PHARMAC subsidies for 51 non-prescription medicines. The prescription medicines are first line treatments for common health conditions, mainly contraceptives and antibiotics, and are already specified prescription medicines for designated registered nurse prescribers under the Medicines Act.

This proposal supports the New Zealand Health Strategy by enabling registered nurses to provide the right care at the earliest opportunity, fully utilising their skills and training (Minister of Health, 2016b). It will remove barriers to access for people within vulnerable communities, including children in lower socio-economic circumstances who are more at risk of bacterial infections that may lead to more serious complications and hospitalisation. It builds on existing programmes which enable registered nurses to administer and supply treatments for skin infections and sore throats under standing orders.

Many registered nurses work in settings without a medical practitioner or access to funded medicines that can be supplied and administered under standing orders. It can be a long process with unnecessary cost and delay for patients to obtain the medicines they need, including having another appointment with a medical practitioner to get a prescription. Prescribing authority will make it easier for patients to obtain the medicines they need; and make better use of the skills of health professionals.

\(^{1}\) Registered nurses working in schools, general practice, public health, well child services, Māori and Pacific Health providers, services for youth, family planning, district nursing and other ambulatory and home based services.
2 Introduction

In 2013 the Council consulted on two proposals for registered nurse prescribing (see Appendix 1). The first proposal (community nurse prescribing) focused on enhancing the role that nurses have in health promotion, disease prevention and the assessment and treatment of minor ailments and illnesses in the community. The Council proposed that suitably qualified nurses working in the community be able to prescribe a limited number of medicines. There was a high level of support for the proposal (from 90% of submitters) with many supporting the Council’s view that limited prescribing would enhance the health services registered nurses are able to deliver and make it easier for patients to obtain the medicines they need. Many submitters expressed reservations about the proposed preparation for prescribing (61%) and the number of medicines (50%). The feedback also indicated a lack of clinical governance in some areas to support community nurse prescribing (see Appendix 2).

The Council decided to progress the second proposal (specialist nurse prescribing) and completed an application for Designated prescriber: Registered nurses practising in primary health and specialty teams in October 2014 (See Appendix 3). It was approved by the Cabinet in November 2015 and the Medicines (Designated Prescriber – Registered Nurses) Regulations 2016 came into force on 20 September 2016. The Council can authorise registered nurses who have completed a post graduate diploma in registered nurse prescribing for long-term and common conditions to prescribe in collaborative teams.

The Council has now modified the “community nurse prescribing” proposal in response to submitters concerns (see Section 12 for Council’s response to the consultation feedback). The Council is planning to introduce registered nurses prescribing in community health under the Medicines (Designated Prescriber – Registered Nurses) Regulations 2016. The Council plans a managed introduction so it can evaluate this model in partnership with Counties Manukau Health and Family Planning New Zealand.

3 Modified proposal and list of medicines

In 2015/16 the proposal was modified after discussions with nurses working in the community, nurse leaders and other stakeholders (see Appendix 4) to focus on specific health conditions that registered nurses are able to treat under standing orders i.e. common skin conditions (such as simple eczema, impetigo, fungal infections and parasites), ear infections, sore throats and provide rheumatic fever prophylaxis and ongoing treatment, pain relief for low level pain, contraception and treatment for common sexually transmitted infections (STIs), urinary tract infections and constipation.

The prescription medicines list has been reduced from 153 to 32 medicines that are first line treatments for common health conditions, mainly contraceptives and antibiotics (see Appendix 5). These medicines are specified prescription medicines under the Medicines (Designated Prescriber – Registered Nurses) Regulations 2016.
In addition other (over the counter) medicines have been included for these registered nurses to “prescribe” under PHARMAC rules due to come into effect in October 2016 (e.g. antifungals, antipruritic medicines, barrier creams and emollients, disinfecting agents and parasiticidal agents). The non-prescription medicines list has been reduced from 110 to 51 medicines. The majority of these are dermatologicals for skin conditions. A small number of devices are also included (see Appendix 5).

Registered nurses prescribing in community health would be restricted to prescribing for normally healthy people without significant co-morbidities using decision support tools (clinical pathways or guidelines). If the individual patient does not fit the criteria they must be referred to a medical practitioner or nurse practitioner. Nurses would only prescribe medicines from the limited list that were relevant to their practice context and agreed with their employer and/or clinical governance group.

There is a possibility of communal harm from wider use of antibiotics. The antibiotics on the medicines list are first line, except where there are specific health conditions where nurses have a role, e.g. sexual health, rheumatic fever prophylaxis. There is a specific requirement within the education for registered nurse prescribers in community health on antibiotic resistance. This includes working with patients to apply non pharmacological strategies, improve health literacy and complete the course of medicines.

An analysis of nurse prescribing in primary health in the United Kingdom (2006-2010) found that the items most frequently prescribed by nurses were antibiotics for sore throats, skin infections, urinary tract infections and STIs, hormonal contraceptives and nicotine replacement therapy (Drennan, Grant, & Harris, 2014). Nurses were responsible for prescribing only 1.5% of the total number of items prescribed in primary care.

4 Preparation for registered nurses prescribing in community health

The preparation for registered nurse prescribing in community health is positioned within a Nursing Council-approved recertification programme provided by a national or regional health provider organisation. The Council believes that the proposed 6 months of education and supervision is now appropriate preparation for the reduced number of health conditions and prescription medicines within the model.

The education programme standards and prescribing competencies that were consulted on in 2013 have been adapted. The content and learning outcomes for the education programme and standards for clinical governance, supervision in practice, credentialing/assessment processes and continuing competence requirements have been included in the Standards for recertification programmes for registered nurse prescribing in community health (see Appendix 6). Clinical governance standards (e.g. policies, professional development, audit, expert advice,  

\[2\] The Council can set or recognise recertification programmes under section 41 of the Health Practitioners Competence Assurance Act (2003).
and decision support tools) support safe prescribing by linking registered nurses with collegial support and current best practice information.

The registered nurses authorised to prescribe will have:

1. a minimum of three years’ clinical experience with at least one year in the area of prescribing practice.
2. completed a Nursing Council approved recertification programme for registered nurse prescribing in community health.
3. completed a period of supervised practice with a designated authorised prescriber (a medical practitioner or nurse practitioner) or a suitably qualified senior nurse, as part of the recertification programme.
4. a limited list of medicines from which they can prescribe within their competence and area of practice.
5. ongoing competence requirements for prescribing.

5 Collaboration and communication

Registered nurses prescribing in community health will be able to make prescribing decisions that will be guided by decision support tools. Registered nurses will be responsible for seeking guidance or referring patients that are beyond their abilities. Integrated models of care require services to work more closely together for the benefit of the patient. It is anticipated that having a large regional health provider supporting this model will improve collaboration and communication with primary health providers. The registered nurse is required to communicate his/her prescribing decisions to the primary health provider where possible.

6 Clinical governance

The Council will required approved organisations to provide clinical governance including an identified senior nurse responsible for developing, implementing and monitoring the structures, policy and process to support safe prescribing. The organisation will have policies and procedures that support registered nurse prescribing including mentorship, continuing professional development and audit processes. The organisation will have a Drug and Therapeutics governing group to provide expert advice and guidance on the safe prescribing of medicines for registered nurse prescribing in community health and provide risk management of adverse events and medication errors. The organisation will have decision support tools consistent with National guidelines for registered nurse prescribing in community health.

7 Proposed managed introduction

The model is designed to be embedded within clinical governance structures as described above. During 2015 it became evident that partner organisations would be needed to develop
the model further in the practice setting. Two partner organisations have agreed to develop the first recertification programmes: Counties Manukau Health and Family Planning. Both organisations serve populations that will benefit from this model.

Counties Manukau Health provides health and disability services to an estimated 534,750 (11% of the total New Zealand population) who reside in the local authorities of Auckland, Waikato and Hauraki District. Counties Manukau has a higher proportion of children than the overall New Zealand population. Twenty-three percent of the population is aged 14 or under (123,400 in 2016). These younger age groups have high proportions of Māori, Pacific and Asian peoples. 58% of all Counties Manukau Māori, 76% of Counties Manukau Pacific peoples, and 45% of the 0-14 years old in Counties Manukau were living in (neighbourhood deprivation) decile 9 and 10 areas at the time of Census 2013. The high proportion of the Counties Manukau population living in socio-economic deprivation has a significant impact on health and health service provision. For example, Counties Manukau has a high rate of illnesses linked to overcrowded and poor quality housing. The avoidable mortality and hospitalisation rates for the Counties Manukau population are higher than the national rates, with Māori and Pacific residents having higher rates than those in Asian and NZ European/Other groups.

Family Planning is a national organisation that specialises in reproductive and sexual health. With 180,000 visits per annum registered nurses undertake consultations and supply or administer 75% of the medicines under standing orders within this service. They initiate medication for 33,000 clients and provide over 100,000 medications and contraceptive devices annually. The current methods they use are not sustainable going forward. Family Planning already has an extensive training programme for nurses to use standing orders and intends to build on this to educate, supervise and monitor nurse prescribers.

A managed introduction will enable the Council to evaluate whether the preparation and support provided within the recertification programmes is appropriate for registered nurses prescribing in community health. In the 2013 consultation there was a mixed response from submitters with many commenting that the proposed training was too short but not suggesting how long it should be (21%). Some submitters proposed one or two postgraduate education papers (14%) and a few thought all registered nurse prescribers should be educated to a postgraduate diploma level (5%) (see Appendix 2). The Council will evaluate the preparation following the initial introduction and may make changes before the model is implemented more widely.

It is planned for up to twenty nurses at each organisation to complete the education and supervised practice before applying to the Council for prescribing rights. Counties Manukau Health would trial the project with nurses from public health, school health and primary care teams. After six months of prescribing practice the evaluation would be completed. The objectives of the evaluation are:

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1. To assess the safety and acceptability of registered nurse prescribing in community health in the different practice contexts, with special focus on the range of medicines and conditions.

2. To assess whether the recertification programme framework provides sufficient clinical governance to support registered nurse prescribing in community health.

3. To evaluate the education, training and support for registered nurses to prescribe medicines safely and appropriately.

4. To assess the benefits (including cost-benefits) for the health system and health consumers.

5. To identify and document enablers and barriers to implementing registered nurse prescribing in community health.

It is anticipated that once the evaluation was complete and any changes were made to the model, Counties Manukau Health could facilitate a wider roll out in the Auckland region and Family Planning would implement this nationally. Counties Manukau Health also intends to develop an e-learning package that can be accessed through Ko Awatea Learn that is available to 11 District Health Boards (DHB) and local primary care nurses. Other DHBs, PHOs or national organisations could apply to access this e-learning and develop similar recertification programmes.

8 Consumer benefits and accessibility

This proposal aligns with the New Zealand Health Strategy in that it seeks to “enable all people working in the health system to add the greatest value by providing the right care at the earliest time, fully utilising their skills and training” and “ensure the right services are delivered at the right location in an equitable and clinically and financially sustainable way” (Minister of Health, 2016b, p. 10).

It also seeks to remove barriers to access for people within vulnerable communities (Ministry of Health, 2015b), including children in lower socio-economic circumstances who are more at risk of bacterial infections that can lead to more serious complications and hospitalisation. Baker et al. (2012) found that children younger than five years are significantly more likely to be admitted to hospital than other age groups. Hospitalisation rates for Pacific peoples and Māori were double those of Europeans. DHBs have responded by introducing nurse-led school clinics where registered nurses can administer and supply treatments under standing orders with positive results e.g. Mana Kidz programme (Anderson et al., 2016; Vogel, Lennon, Gray, Farrell, & Anderson, 2013). This proposal builds on this work and supports the health systems level measures to reduce ambulatory sensitive hospitalisations. Prescribing rights would enable

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4 New System Level Measures to be implemented from 1 July 2016 includes Ambulatory sensitive hospitalisation (ASH) rates per 100,000 for 0–4 year olds (Ministry of Health, 2016).
more people who have a skin infection to be treated by a registered nurse, preventing development of more serious complications, and avoiding hospitalisations.

Reducing rates of acute rheumatic fever is a government health priority linked to the same socio-economic and ethnic profile as skin infections (Ministry of Health, 2015c). The Ministry of Health has funded sore throat services in schools in high risk areas where primary prevention of rheumatic fever can be initiated by nurses under a standing order based on a national guideline (Anderson et al., 2016). Children who contract the disease require many years of prophylactic antibiotics to prevent more serious cardiac disease (Heart Foundation of New Zealand, 2014)\(^5\). Access to primary healthcare whether because of cost or other factors such as family mobility have been identified as barriers to treatment (New Zealand College of Public Health Medicine, 2015). Acute rheumatic fever and rheumatic heart disease (RHD) comprise a burden of mortality and hospital cost concentrated largely in middle age. Māori and Pacific RHD mortality rates are substantially higher than those of non-Māori/Pacific (Milne, Lennon, Stewart, Vander Hoorn, & Scuffham, 2012). This proposal builds on the role of registered nurses in patient education, health literacy screening and treating Strep A sore throats, and providing prophylactic antibiotics.

This proposal also seeks a greater role for community nurses in sexual and reproductive health which is in line with the Ministry of Health’s (2001) Sexual and reproductive health strategy. Access to contraception and prevention of teen pregnancy are particular issues for youth consumers (Minister of Health, 2016a). New Zealand also has significant rates of sexually transmitted infections (STIs)\(^6\). 83% of people with Chlamydia and 73% of people with gonorrhoea reported in 2014 were aged between 15 and 29 years and the highest rates were reported in the Māori and Pacific peoples ethnic groups. Māori females aged 15–19 years reported the highest rate by age group and sex for both infections (The Institute of Environmental Science and Research Ltd, 2015).

Proactive use of contraceptives is preferable to prevent unwanted pregnancy and STIs. Registered nurses can provide contraceptive services in family planning, sexual health and youth services including secondary schools (Ministry of Health, 2014) and in general practice. Prescribing rights for nurses enables more people to access simple contraception more easily. It also allows the registered nurse to take full responsibility for the provision of the medicine and facilitates interprofessional team work. Registered nurses undertaking consultations for contraception, urinary tract infections and simple STIs would allow medical practitioners to assess and monitor more complex patients that used to be seen at hospital outpatient clinics.

**9 Why not continue with standing orders?**

There is little New Zealand research on the use of standing orders in primary health care. A national survey completed in 2013 found that standing orders were used frequently and for a

\(^5\) Anecdotal evidence suggests some of these children frequently move house and do not attend a general practice consistently.
range of conditions and problems that had a high degree of diagnostic certainty (Wilkinson, 2015a). The study identified some misunderstandings about their use and that medical practitioners did not always take up their full responsibilities as the issuers of the orders. Lack of medical support was an important reason identified by nurses for not using standing orders, including getting all GPs in an area to agree to standing order use and a lack of medicines being available on site.

Wilkinson (2015b) found that the majority of nurse respondents reported a need to improve access to medicines and identified barriers such as poor availability of medical practitioners, costs of medical practitioners’ visits and transport difficulties. Children were identified as being particularly vulnerable because of the reliance on an adult to take them to a GP. “Public health nurses are mobile, so can assess and treat people in their homes...currently we are too constrained and spend too much of our time persuading people to go to the GP, or helping to access funding for the GP visit” (Wilkinson, 2015b, p. 303).

Many registered nurses work in settings without a medical practitioner or a supply of funded medicines that can be supplied and administered under standing orders. In some settings such as large secondary schools there may be students enrolled in multiple general practices or who are not enrolled which makes the agreement of standing orders difficult. In other settings including Family Planning and Mana Kidz Programme there can be a long process to enable patients to get the medicines they need including “pre-signing” and “post-signing” of prescriptions by a medical practitioner. The Ministry of Health has used an adaptation of the practitioner supply order and standing orders framework with no co-payment to enable the Rheumatic Fever Prevention programme (Ministry of Health, 2015c). Audit of standing orders is time consuming and has been reported as being completed by senior nurses because medical practitioners decline to do this work (Wilkinson, 2015a). ‘How they [standing orders] are supposed to be used does not quite fit with how they are used in practice’ (Scott-Jones, 2013).

In other settings patients must be redirected to have another appointment with a medical practitioner to get a prescription. This creates unnecessary cost and time delay for the patient and is inefficient provision of health services. In some areas appointments to see a medical practitioner are difficult to obtain (Ministry of Health, 2015a) and some patients do not access primary care because of cost (Minister of Health, 2016a), transport and poor health literacy. Access for Māori and Pacific peoples is poorer than for other ethnic groups.

Family Planning registered nurses already provide nurse-led clinics for patients and often prescribe by proxy (the nurse assesses the patient and determines the medicine to be prescribed but the medical practitioner signs the prescription). This service model provides more timely and convenient patient access to medicines and makes better use of both medical practitioners and registered nurses’ skills and knowledge.

The standing orders process (and prescribing by proxy) places medical practitioners in the position of taking responsibility for patients they have not assessed (Medical Council of New Zealand, 2016). Prescribing authority for registered nurses make them more clearly

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7 In Family Planning 75% of “prescribing” decisions are made by nurses under standing orders.
accountability for their prescribing decisions and ensures they have the education, training and support. Registered nurses are interested in becoming prescribers and believe it will benefit their patients. 82% of the 304 registered nurses surveyed by Wilkinson (2015b) were interested in community nurse prescribing. Preliminary findings of a survey this year found that 68% (34 out of 50) public health nurses believed that prescribing would assist them with their role (Owen, 2016).

10 Why have more than one model of registered nurse prescriber?

Internationally different models of prescribing have developed and have been shown to be safe and successful (Nissen et al., 2010). Different models can be used to cater for different skill levels and responsibilities (Nissen et al., 2010, p. 9). In the United Kingdom (UK) suitably qualified registered nurses can prescribe independently, from a limited community practitioner formulary, or be a supplementary prescriber (prescribe according to an agreed individual patient care plan in partnership with an independent prescriber) (Royal College of Nursing Publishing, 2013). In 2013 Health Workforce Australia nominated three prescribing models - autonomous prescribing, partially autonomous prescribing and protocol prescribing. It was recognised that “different models of prescribing recognise the diverse needs of people taking medicines” and the prescribing model can differ based on the education, role and responsibility of the health professional (Health Workforce Australia, 2013, p. 4). Protocol based administration and supply by registered nurse in rural and isolated practice areas has been used for many years to meet the needs of remote populations.

In Canada several provinces are introducing registered nurse prescribing to meet the needs of remote populations or because of legislative barriers that do not allow standing orders. These models are based on registered nurses using decision support tools (Canadian Nurses Association, 2015).

The Council is of the opinion that the two models for registered nurse prescribing will provide flexibility for different patient needs.

11 How registered nurse prescribing in community health differs from other nurse prescribers in New Zealand

Table 1 (see below) compares the three models of nurse prescribing in New Zealand. Different models can be used by health services to cater for different patient groups and different responsibilities. It also means that education can be tailored to the level of prescribing and does

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8 In 2014/15 there were 981 nurses with endorsements for scheduled medicines registered nurses (rural and isolated practice) (Nursing and Midwifery Board of Australia, 2016).
not require all nurse prescribers to complete a postgraduate diploma or a masters’ degree which can be significant barriers. Funding and resourcing of postgraduate education and prescribing practicums (including mentor time) is limited. The Council anticipates that these models will in time form a career pathway for nurses in primary and community health and encourage the further development of the nurse practitioner workforce.

Table 1: Comparison of nurse prescribing models in New Zealand

<table>
<thead>
<tr>
<th></th>
<th>Proposed Registered nurse prescribing in community health</th>
<th>Registered nurse prescribing in primary health and specialty teams</th>
<th>Nurse practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescribing authority</strong></td>
<td>Designated prescriber: Able to prescribe from a limited schedule of medicines.</td>
<td>Designated prescriber: Able to prescribe from a schedule of common prescription medicines.</td>
<td>Authorised prescriber: Able to prescribe any prescription medicine.</td>
</tr>
<tr>
<td><strong>Scope of practice</strong></td>
<td>Must be credentialed on a recertification programme for registered nurse prescribing in community health. Uses clinical pathways/guidelines to treat a small number of conditions for normally health people.</td>
<td>Must work in a collaborative team with an authorised prescriber available for consultation. Able to diagnose and treat common conditions (e.g. asthma, diabetes, hypertension) within a collaborative team.</td>
<td>Able to independently assess, diagnose and treat a range of conditions for a population group in an area of practice. May work autonomously or within a health care organisation. Consults with health professional colleagues when relevant.</td>
</tr>
<tr>
<td><strong>Additional Qualification</strong></td>
<td>Recertification programme including education, supervision in practice and credentialing.</td>
<td>Post graduate diploma in registered nurse prescribing for long-term and common conditions.</td>
<td>Clinical Master’s degree in nursing.</td>
</tr>
</tbody>
</table>

12 The Council’s response to consultation feedback

The Council began consulting with relevant groups in February 2012. Details of the formal written consultation process on community nurse prescribing in 2013 are included in Appendix 3 (section 9). The proposal has been renamed ‘Registered nurses prescribing in community health’. The reasons for the change are discussed below under ‘Title’.

12.1 Support for the community nurse prescribing proposal

A large majority of submitters (90.2%) agreed with the proposal that suitably qualified and experienced registered nurses be able to prescribe from the community nurse prescribing lists
of medicines. The majority of submitters (91%) agreed that community 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 registered nurses and fragmentation of care. The Council has responded to these concerns by limiting the health conditions and the medicines that registered nurses can prescribe, linking nurse prescribing to decision support tools (clinical pathways and guidelines) and positioning nurse prescribing within a recertification programme with requirements for clinical governance, education, supervision and continuing competence. The standards and competencies (Appendix 6) require the prescriber to consider 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 submitters reported a preference for 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. Delegated prescribing was included in the Medicines Act (1981) in 2015 but has not been used in New Zealand to date. The legislation suggests that a greater number of regulations are required (than for designated prescribing) many relating to the authorised prescriber’s responsibilities and the delegated prescribing orders. The Council believes this approach is unnecessary and that limited prescribing can be managed through scope of practice, education, guidance and clinical governance.

**12.2 Title**

The title of ‘community nurse prescribing’ was not well supported with 71% of submitters opposed. Many felt the title was too confusing. Many submitters supported “primary health prescriber”, “registered nurse prescriber” or “Level 1 prescriber”. Some thought the prescribing authority was too narrow and should encompass both secondary and aged residential care. Now that the medicine lists have been reduced it is clearer that registered nurses in those contexts should be prepared at postgraduate diploma level for registered nurse prescribing in primary health and specialty teams. Other title suggestions were “limited”, “restricted” or “protocol” prescribing.

The initial proposal sought to build on the role that nurses have in health promotion and prevention and the premise was that these prescribers would be working with normally healthy people. The Council decided to use the title *Registered nurses prescribing in community health* as it describes the context and the “normally healthy people” the prescribing authority is intended for rather than a title for the nurse.
12.3 Preparation for prescribing

The Council proposed that community nurse prescribing courses should include up to six days of theory (online and workshop) and three days of prescribing practice with a medical practitioner or nurse prescriber (authorised prescriber). A competence assessment with a medical practitioner or nurse practitioner would be one of the assessments that must be successfully completed before the nurse would be authorised by the Council to prescribe.

Only 39% of submitters supported the qualification and training proposed by the Council (see Attachment 1, section 5.4). Many of those who were opposed based their response on the breadth and content of the proposed medicines schedule requiring a higher level of preparation or a longer period of preparation.

Sixty two per cent of submitters supported the clinical experience proposed by the Council of three years’ equivalent full-time practice. At least one year must be in the area of practice she/he will be prescribing.

In 2013 the Council consulted on education standards and competencies for community nurse prescribing. Whilst many submitters did not support the proposed qualification and training, more supported the education programme standards (47.5%) and competencies (60%) commenting that they were comprehensive, achievable and robust and ‘do-able’ from an education provider perspective.

The preparation for community nurse prescribing has been modified based on the range of medicines and conditions being significantly reduced. The preparation will build on existing sector resources including education packages and protocols that have been developed for nurses to supply and administer medicines under standing orders. The inclusion of decision support tools (clinical pathways or guidelines) and a clinical governance framework provided by an accredited organisation provides additional support to ensure the safety of registered nurse prescribing in community health.

The modified model has now been embedded within clinical governance structures by positioning the preparation within a recertification programme. The original education standards and competencies have been adapted and standards for clinical governance (i.e. organisation/employer provision of policies, professional develop, audit, expert advice, decision support tools etc.), supervision in practice, credentialing/assessment processes and continuing competence requirements have been added (see Appendix 6 Draft standards for recertification programmes for community nurse prescribing).

As discussed earlier, the Council can set or recognise recertification programmes for community nurse prescribers under section 41 of the Health Practitioners Competence Assurance Act (HPCA Act). At present the Council approves Professional development and recognition programmes for continuing competence purposes that are developed by employers. This mechanism allows the Council to set standards and approve programmes that are not prescribed qualifications for scope of practice.
12.4 Continuing competence and monitoring for community nurse prescribing

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

Most submitters (71%) agreed with the ongoing continuing competence requirements for community nurse prescribers. Some concern was expressed about the practice hours being too short, too restrictive, and hard to evidence or define. Some suggested numbers of scripts or patient assessments be used.

Regular professional development to update prescribing knowledge and the monitoring of prescribing competence through peer review, audit or credentialing will be maintained by the accredited organisation and reported to the Council three yearly. The Council will also require evidence that prescribing is incorporated into current practice.

12.5 List of prescription and non-prescription medicines

50% of submitters supported the prescription medicines list and 85% supported the non-prescription list (See Attachment 1, sections 5.8 and 5.9). A variety of issues were identified for the prescription medicines list including the number of medicines, the inclusion of high risk medicines, the number of antibiotics and the need to specify form and route of some medicines.

The lists of prescription and non-prescription medicines and devices has been reduced and focused on medicines that are often supplied by registered nurses under standing orders. The prescription medicines list has been reduced from 153 to 32 medicines that are first line treatments for common health conditions. The health conditions chosen have decision support tools (either guidelines or standing orders) available. The patients these registered nurses would prescribe for would be normally healthy people without significant co-morbidities. The original non-prescription medicines list of 110 items has also been reduced to 51 medicines. Most of these are dermatologicals for common skin conditions.

*These changes have significantly reduced the scope of the community nurse prescribing authority and address the concerns from submitters related to the list of medicines.*
13 References


