Guidelines for registered nurses prescribing in primary health and specialty teams

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1 Introduction
This guideline has been developed by the Nursing Council to provide advice to registered nurses prescribing in primary health and specialty teams on maintaining safe prescribing practice within a collaborative healthcare team.

1.1 Legal framework for registered nurse prescribing

The Medicines Act 1981 allows regulations for designated prescribers. The Medicines (Designated Prescriber-Registered Nurses) Regulations 2016 and the Misuse of Drugs Regulations allow suitably qualified registered nurses to prescribe specified prescription medicines and controlled drugs. The qualifications, training, assessment and continuing competence requirements for registered nurses seeking to be authorised by the Council are set out in a Gazette notice made under these regulations¹. The prescription medicines have been specified by the Director General of Health in a Gazette notice and are included in the Medicines list for registered nurse prescribing in primary health and specialty teams 2016 on the Council website.

1.2 Professional regulation and guidance for registered nurse prescribing

The role of the Nursing Council is to protect the health and safety of the public by setting standards for nurses under the Health Practitioners Competence Assurance Act (2003). Standards for registered nurses prescribing in primary health and specialty teams are set out in the following documents:

- Competencies for registered nurses (Nursing Council of New Zealand, 2007).
- Competencies for nurse prescribers (Nursing Council of New Zealand, 2016).
- The Code of Conduct for nurses (Nursing Council of New Zealand, 2012) which sets standards of professional behaviour for all nurses.

1.3 Competencies for nurse prescribers

The Competencies for nurse prescribers have been adapted from an Australian Competency Framework for all prescribers². The competencies describe the activities that are essential for safe, appropriate and effective prescribing including patient assessment, clinical reasoning, monitoring and communication skills. They also apply principles of quality use of medicines and professional behaviour, particularly Competency Area 5: Practices professionally. These competencies outline the expected standard of prescribing practice

¹ More information on the qualifications, training and assessment requirements before a registered nurse is permitted to commence prescribing in primary health and specialty teams is outlined in the Council’s Preparing to prescribe in primary health and specialty teams: Guidance for registered nurses and employers (2016). This document also explains why registered nurse prescribing has been introduced and the clinical governance and support that needs to be in place for registered nurse prescribing.

This guideline contains more detailed advice on the extent of your prescribing authority and professional accountabilities, the requirement to practise within a collaborative team, and the schedule of specified prescription medicines and controlled drugs. These guidelines are designed to augment the clinical policies and governance processes in the practice setting.

2 Prescribing authority and accountabilities

2.1 Registered nurse scope of practice

Registered nurses prescribing in primary health and specialty teams practise within the registered nurse scope of practice (see Appendix 1). The prescribing of medicines complements other activities that registered nurses contribute to the clinical management of people with long-term and common conditions. As a regulated health practitioner with prescribing authority you are accountable for the prescribing decisions you make. The breadth of patient conditions and diagnostic skills expected of you is not the same as that of a doctor or a nurse practitioner. You are required to work with a collaborative team and to seek advice or refer patients with complicated, complex or uncertain health conditions which are beyond your experience and education to a doctor or nurse practitioner within the team.

As a registered nurse with designated prescribing rights you have a narrower scope of prescribing practice than that of a medical practitioner or nurse practitioner (authorised prescribers). You must seek advice or refer patients who are outside your level of competence. You may 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 must be discussed with an authorised prescriber.

You must work under supervision of an authorised prescriber (a doctor or a nurse practitioner) for 12 months after you attain prescribing rights. Ongoing case or peer review to support your ongoing learning is recommended.

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 time limited and is flexible depending on the nurse’s requirements. Closer supervision is usually required in the beginning and decreases over time once the nurse and the supervisor become confident with clinical reasoning and prescribing decisions.

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3 Nurse practitioners have additional areas of responsibility and accountability that are included in their scope of practice and competencies.
2.2 Safe prescribing practice for registered nurses in primary health and specialty teams

Prescribing is a complex process and it may be associated with unintended consequences and adverse events. It is therefore important that you understand the medicine being prescribed including possible side effects and interactions with other medicines. It is also important that risk is minimised through comprehensive and accurate documentation of the prescribing consultation.

You need to determine the medicines and conditions you will prescribe for based on your specific area of practice and your competence to prescribe a particular medicine.

You will provide safe and competent care by:

**Understanding your accountabilities**

- Understanding your level of competence and accountability, and confining your prescribing to health conditions and medicines within your clinical knowledge for patients you know and who are under the care of the team you are working with.
- Only prescribing prescription medicines from the specified schedule relevant to your area of practice and competence.
- Using protocols and best-practice evidence to guide your prescribing decisions.
- Being familiar with the New Zealand Formulary which contains information to help you prescribe.\(^4\)
- Maintaining your competence by keeping up to date with the medicines and management of the health conditions you prescribe for and by regularly using your prescribing skills.
- Completing annual continuing competence requirements outlined in Appendix 3.
- Documenting prescriptions according to legal requirements and quality standards.\(^5\)
- If you extend your prescribing activities or change practice context you are responsible for ensuring you undertake appropriate training and supervision before prescribing.

**Working in a collaborative team**

- Working with an experienced prescribing mentor in the clinical setting and participating in regular case review and peer review of your prescribing practice.
- Accessing patients’ clinical records including medical history, examinations, test results and allergies to medicines.
- Ordering tests and reviewing test results as part of a team.
- Ensuring appropriate professionals are aware of your role, e.g. the community pharmacists.

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\(^4\) Advice on Medication safety when prescribing from the Medication Safety Expert Advisory Group can be found in the New Zealand Formulary nzf.org.nz

Working in partnership in the best interests of the patient

- Sharing decision making with the patient, informing them of the risks and benefits.
- Making prescribing decisions based on clinical suitability and the best interests of the patient that are not influenced by bias.
- Arranging appropriate monitoring and educating patients on self-monitoring for side effects.
- Taking appropriate action if a medication error is made (during prescribing, dispensing or administration) to ensure the patient is not harmed and the error is reported.
- Managing and reporting adverse effects (Centre for Adverse Reactions Monitoring-CARM see https://nzphvc.otago.ac.nz/).

2.3 Legal limitations for designated prescribers

Designated prescribers are not permitted to:

- prescribe prescription medicines that are not specified under regulations (Medicines Act, 1981),
- issue standing orders (Standing Orders Regulations, 2002),
- sign prescriptions for patients who are not under their care (Regulation 39, Medicines Regulations 1984),
- prescribe unapproved medicines (Section 25, Medicines Act, 1981),
- prescribe a controlled drug for a person you have reason to believe is dependent on controlled drugs or for treatment of dependency (Section 24 (1A) Misuse of Drugs Act 1977).

As a registered nurse prescribing in primary health and specialty teams you must not:

- write a prescription for yourself or anyone you have a close personal relationship with,\(^6\),
- repeat a prescription for a patient you have not assessed in a face-to-face consultation,
- prescribe using telemedicine (see box below) unless this is a service established within your primary health or specialty team according to established guidelines. You should be working alongside an authorised prescriber (i.e. a shared clinic model) and ensure you practise according to the guidance on prescribing\(^7\) in this context,
- prescribe for another prescriber or at the request of a professional colleague.
- give verbal/telephone orders for medicines. Medicine prescriptions must be documented in writing, faxed or communicated electronically,

\(^6\) Further guidance can be found in Nursing Council of New Zealand (2012) Guidelines: professional boundaries.

\(^7\) See NZ Telehealth Resource Centre Guideline for Establishing and Maintaining Sustainable Telemedicine Services in New Zealand (2015) (section 4.6) and Medical Council of New Zealand Statement on Telehealth (June 2013).
prescribe medicines for unapproved uses or age groups unless this is a practice supported by evidence and the patient has been informed.

Telemedicine refers specifically to real-time videoconference consultations with direct patient involvement. Telemedicine allows a patient and clinician (health professional) to see and talk to each other, even though they are in different locations. This has a number of benefits including avoiding travel for the patient or clinician, giving the patient access to specific expertise, and decreasing the time patients wait to be seen if face-to-face visits are not frequent enough to keep up with demand for the service. Telemedicine can allow a clinician present with the patient to have access to specialist advice and support. The use of video allows the transfer of more clinical information more accurately than a telephone consultation, and also allows the consultation to be many to many, rather than one to one.


3 Collaboration and communication

Although you are able to make independent prescribing decisions, you are required to have a collaborative working relationship with a healthcare team that includes an authorised prescriber (a medical/nurse practitioner) with whom you can readily consult. This will ensure professional support and advice are available. An integrated model of 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.

Ideally all of those involved in patient care would use a shared patient record but if that is not available you must use other mechanisms to communicate with other prescribers including phone calls, emails or letters. You must communicate your prescribing decisions with members of the patient’s healthcare team (especially the patient’s primary care provider). Relevant information regarding the patient’s health status, the patient’s current and recent use of medicines, as well as the patient’s health conditions, allergies and/or adverse reactions to medicines, needs to be reported so everyone involved in caring for the patient can work effectively to support the patient’s care.

Team-based care is defined as “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).

Collaboration includes “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).

4 Prescription medicines

4.1 Commonly used medicines for common conditions
The Medicines list for registered nurse prescribing in primary health and specialty teams 2016 has been developed from the New Zealand Formulary and the Community Pharmaceutical Schedule. The list contains commonly used medicines for common conditions. It is focussed on prescribing for long-term and common conditions within primary healthcare 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.

4.2 Requirements as to use, route of administration or pharmaceutical form.
Restrictions related to route, context and continuation prescribing have been included in the Medicines list for registered nurse prescribing in primary health and specialty teams 2016 schedule to provide greater clarity about the specific form of the medicine and the circumstances under which it can be prescribed.

4.3 Continuation prescribing
There are some medicines in the schedule listed that must be initiated by an authorised prescriber, e.g. a doctor or a nurse practitioner. As part of the care plan the designated prescriber may assume responsibility and authority for prescribing continuation of the medicine. The designated prescriber is accountable for ongoing assessment and monitoring, re-ordering and/or making adjustments to the medicine and referral as needed as part of the team-based care.

Continuation prescribing is different from ‘repeat’ prescribing where a prescriber signs a script for a patient based on a previous consultation (see Glossary).

4.4 Ophthalmology medicines
Most of the medicines on the prescription schedule for eye health are restricted to registered nurses working in ophthalmology teams. The reason for this is 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 and ongoing monitoring.

4.5 Prescribing for children
Prescribing for children is a specialised area and you must ensure you have the appropriate training and experience, and have been deemed competent to prescribe for children in your

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9The 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.
area of practice. Specific guidance is available on prescribing for children in the New Zealand Children’s Formulary.

4.6 High-risk medicines
Potential for harm increases when prescribing high-risk medicines. Many of these medicines have not been included in the schedule. Some anticoagulants, insulins and opioids have been included on the lists. Particular care must be taken to ensure dosing is correct, the right product is prescribed or dispensed, monitoring is maintained, interactions with food, other medicines and herbal products are identified, and side effects are minimised, e.g. anti-emetics and laxatives are prescribed when appropriate.

### High-risk medicines

The medicines most frequently involved in serious adverse drug events are called high-risk medicines. Special attention is needed when they are prescribed, dispensed, supplied, stored, administered or taken.

Factors that increase high-risk medicines’ potential for harm include having a narrow therapeutic index, complex or unusual dosing, high monitoring requirements, significant interactions with other medicines, herbal products and food, availability in multiple strengths and forms, look-alike, sound-alike naming and packaging.

Errors are not necessarily more common with high risk medicines. But if errors are made there is more likely to be harm and often the consequences for patients are more serious. Patients suffer and there are extra costs to the healthcare system.

From Health Quality & Safety Commission: *High-risk medicines fact sheet (October 2014).*

**Titration** involves adjusting the levels of a medicine until a desired outcome is met; for example titration of warfarin according to INR results. If titration is to be undertaken by the administrator of the medicines, e.g. another registered nurse, you must ensure specific titration guidelines are included, including specifying the range of dosages and the patient indications for the range.

Further guidance on medicines is included in the *Medicines list for registered nurse prescribing in primary health and specialty teams 2016*
Glossary

**Authorised prescribers:** An authorised prescriber is able to prescribe all medicines appropriate to their scope of practice and unlike a designated prescriber (see below), is not limited to a list of medicines specified in regulation (includes doctors, dentists, nurse practitioners, optometrists and midwives).

**Case review:** Involves reviewing and giving feedback on prescribing activities including

- reviewing of clinical notes, lab results and copies of scripts written to enhance the nurse’s knowledge and clinical practice skills;
- discussing difficult or unusual cases; and
- discussing general related topics as they arise.

**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).

**Competence:** The combination of skills, knowledge, attitudes, values and abilities underpinning effective performance.

**Continuation prescribing:** An authorised prescriber initiates treatment with the medicine. As part of the care plan the designated prescriber assumes responsibility and authority for prescribing continuation of the medicine. The designated prescriber is accountable for ongoing assessment and monitoring, re-ordering and/or making adjustments to the medicine and referral as needed (Ministry of Health, 2016).

**Designated prescriber:** A person who can prescribe medicines within their scope of practice, for patients under their care, from the list of medicines specified in their designated prescriber regulations.

**Patient:** An individual who receives nursing care or services. This term represents health consumers, clients, residents or disability consumers. This term reflects ‘health consumer’ as referred to in the Health Practitioners Competence Assurance Act (2003).

**Prescribing:** The steps of information gathering, clinical decision making, communication and evaluation which result in the initiation, continuation or cessation of a medicine.

**Prescribing mentor:** An authorised prescriber who works within the same multidisciplinary team as the registered nurse with whom she/he can readily seek advice on diagnosis and prescribing as required.

**Prescribing practice:** Participation in patient consultations that includes 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.*
Primary health: Relates to the professional healthcare provided in the community, usually from a general practitioner (GP), practice nurse, pharmacist or other health professional working within a general practice. Primary healthcare covers a broad range of health services, including diagnosis and treatment, health education, counselling, disease prevention and screening.

Repeat prescribing: A prescriber completes a prescription for the same medicines based on a previous consultation without seeing the patient again.

Specialty teams: Groups of health professionals including senior medical practitioners, nurse practitioners and registered nurses who support patients with particular chronic conditions; for example, respiratory or cardiovascular health concerns. Teams are often based in hospital outpatient settings and hold regular clinics to assess or review long-term condition management of patients.

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 time limited and is flexible depending on the nurse’s requirements. Closer supervision is usually required in the beginning and decreases over time once the nurse and the supervisor become confident with clinical reasoning and prescribing decisions.

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 co-ordinated, high-quality care” (Mitchell et al., 2012).

Titration involves adjusting the levels of a medicine until a desired outcome is met.
References


Medicines (Designated Prescriber-Registered Nurses) Regulations. (2016).

Medicines (Standing Order) Regulations. (2002).


Misuse of Drugs Amendment Regulations. (2016).


Appendix 1: The registered nurse scope of practice
(from 20 September 2016)

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. Some nurses who have completed the required additional experience, education and training will be authorised by the Council to prescribe some medicines within their competence and area of practice.
Appendix 2: How to fill in prescription form correctly

In accordance with the Medicines Regulations (1984), section 41, all prescriptions shall

(a) be legibly and indelibly printed; and

(b) be signed personally by the prescriber with their usual signature (not being a facsimile or other stamp), and dated; and

(c) set out the address of the prescriber; and

(d) set out –

(i) the title, surname, initial of each given name, and address of the person for whose use the prescription is given; and

(ii) in the case of a child under the age of 13 years, the date of birth of the child; and

(e) indicate by name the medicine and, where appropriate, the strength that is required to be dispensed; and

(f) indicate the total amount of the medicine that may be sold or dispensed on the one occasion, or on each of the several occasions, authorised by that prescription; and

(g) if the medicine is to be administered by injection, or by insertion into any cavity of the body, or by swallowing, indicate the dose and frequency of the dose; and

(h) if the medicine is for application externally, indicate the method and frequency of use; and

(i) if it is the intention of the prescriber that the medicine should be supplied on more than one occasion, bear an indication of-

(i) the number of occasions on which it may be supplied; or

(ii) the interval to elapse between different dates of supply; or

(iii) the period of treatment during which the medicine is intended for use.
# Appendix 3: Continuing competence requirements

## Professional development
You are required to complete 20 hours of prescribing-related 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
You are required to complete 40 days of prescribing practice per year.
Prescribing practice is defined as “participation in patient consultations that includes 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
A prescribing mentor is an authorised prescriber who works within the same collaborative team with whom you can readily seek advice on diagnosis and prescribing as required.

## Frequency of monitoring
You are required to submit evidence annually when applying for your practising certificate that you have maintained your competence in prescribing. This includes a competence assessment or a letter of support from the prescribing mentor/supervisor.