Registered Nurse Prescribing: Background document and literature review

Te Kaunihera Tapuhi o Aotearoa
Nursing Council of New Zealand

Contents

Introduction

Registered nurses have been actively engaged in prescribing practice in Aotearoa New Zealand since legislation was passed in 2011, enabling nurses working in diabetes health to prescribe. While small adjustments to the structure and function of nurse prescribing have occurred in the intervening period, no substantial review of registered nurse prescribing (RNP) has been undertaken to date.

As part of a review of the mātanga tapuhi nurse practitioner (NP) scope of practice, Te Kaunihera Tapuhi o Aotearoa New Zealand Nursing Council of New Zealand (the Council) is undertaking a review of registered nurse prescribing (RN prescribing). The purpose of the NP review is to ensure nursing practice appropriately reflects contemporary nursing environments now and into the future to support health equity in local communities. RN prescribing is inextricably linked to the NP education pathway due to the ability to credit the postgraduate diploma in registered nurse prescribing to a mātanga tapuhi nurse practitioner master's programme. With the two education standards being linked, it is appropriate to review the RN prescribing programme concurrently and for the same purpose.

This paper provides an overview of RN prescribing including the historical context, legislative background, workforce, regulation, the international context of nurse prescribing and evidence of outcomes.

Te Tiriti o Waitangi

The Council carries out its functions within the context of its commitments, responsibilities and obligations under Te Tiriti o Waitangi, and has recently updated its Te Tiriti o Waitangi policy statement. This review of RN prescribing recognises the Council's commitment to, and the position of, Te Tiriti o Waitangi. We acknowledge the importance of health equity and its contributing factors (including colonisation) and work to provide culturally safe care. Implementing these expectations is a way we can support nurses to deliver care which is responsive to the rights and needs of tangata whenua and does not further perpetuate existing health inequities. The Council acknowledges and values the unique role of Māori nurses in achieving Māori health equity through actively engaging with, and listening to, Māori nurses.

The Council's regulatory role in registration

The Council, under the Health Practitioners Competence Assurance Act 2003 (the HPCA Act), is the responsible authority that governs the practice of nurses. The principal purpose of the HPCA Act is to protect the health and safety of members of the public by

providing mechanisms to ensure health practitioners are competent and fit to practise their professions. The Council sets and monitors standards in the interests of the public and the profession. The Council's primary concern is public safety.

The Council's functions under the HPCA Act includes setting scopes of practice and accrediting and monitoring education programmes. The Council's strategic priority is to ensure standards and competencies are enabling, appropriate, relevant and reflect the future of the nursing profession.

RN prescribing background - past to present

The prescribing of medicines is regulated under the Medicines Act 1981 (the Medicines Act) and subsequent regulations and amendments. The original legislation limited prescribing of medicines to medical practitioners, veterinary surgeons and dentists, known as authorised prescribers. There were minimal limitations to what those groups could prescribe. Midwives were later added as authorised prescribers although limited to prescribing within their scope of practice.

Following the introduction of the HPCA Act, development and subsequent regulation of the NP scope of practice opened opportunities to extend prescribing beyond those identified in the original Medicines Act. In 2005, the Medicines (Designated Prescriber: Nurse Practitioner) Regulation[1] was passed, allowing mātanga tapuhi nurse practitioners to prescribe within their specific area of practice from a formulary of 1,379 prescription medicines as 'designated prescribers'. This regulation was revoked in July 2014 after the Medicines Amendment Act passed into law in 2013 and NPs became fully authorised prescribers. The only limitation to their prescribing practice now is medicines described in Section 29 of the Medicines Act 1981.[i]

Although there was appetite to widen access to prescribing to further groups of nurses following the 2005 NP regulations, progress remained slow (despite the Council having discussions around nurse prescribing since 1994).[2]

In 2007, the Ministry of Health consulted on a proposal to introduce collaborative prescribing defined as "a non-prescribing health practitioner, after authorisation from

[i] Section 29 of the Medicines Act limits the ability to prescribe unapproved medicines to medical practitioners alone. This has been particularly problematic for NPs due to international medicine shortages resulting in unapproved medicines being supplied to replace commonly used medicines. As a result, the NP is unable to prescribe for patients, impacting on both acute practice and continuity of care. As at August 2025, a bill is before Parliament requesting changes to Section 29 that will address this issue.

their registration authority, may prescribe under the supervision of an authorised prescriber". The Council submission indicated cautious support for this proposal as long as NPs became authorised prescribers, and registered nurse prescribers were approved to become designated prescribers.

In 2008, the Council began consulting with professional groups regarding registered nurses becoming designated prescribers under the Medicines Act, with support from the Minister of Health. This work was suspended because of a change in government direction.

In March 2009, the Council again considered nurse prescribing and decided to convene a meeting of key stakeholders. In August 2009, the Chief Nurse promoted a model of prescribing that included authorised and collaborative prescribers but omitted designated prescribing. The then National Nursing Organisations (now National Nurse Leaders group NNLg) supported this with some reservations and with the proviso that the Council would need to regulate nurse prescribers.

In 2010, using funds from the Nursing Innovation Scheme, the New Zealand Society for the Study of Diabetes Incorporated (NZSSD) was commissioned by the Ministry of Health to establish four demonstration sites to test the effectiveness and safety of diabetes nurse specialist (DNS) prescribing. Nurses prescribing during the pilot were working under the Medicines (Designated Prescriber – Registered Nurses Practising in Diabetes Health) Regulations 2011. Eleven nurses were authorised to prescribe a limited formulary of 12 medicines in diabetes health. This model was based on prescribing for a particular disease state. Evaluation of the pilot was favourable, showing prescribing by the nurses was safe, good quality and clinically appropriate, and was highly satisfactory to patients.[3]

Following the success of the DNS prescribing pilot, then Minister of Health Tony Ryall extended an invitation to the Council to make an application under the existing Medicines Act (1981) for more nurses to prescribe under the designated prescriber framework.

In early 2013, the Council then consulted on two proposals for registered nurse prescribing. The Council proposed that enabling more nurses to prescribe would contribute to the health of New Zealanders, particularly those groups who find it difficult to access services. The Council also considered future health needs when developing the proposals, recognising nurses are increasingly required to expand their skills and knowledge in response to changes in health service delivery and to meet the health needs of New Zealanders with lifestyle and chronic diseases.[4] The two proposals considered the areas where nurse prescribing had the most potential to make services

more accessible and timely for patients, and how it might complement the role of other health professionals, including the mātanga tapuhi nurse practitioner.

Overall, there was strong support for the Council's proposals and the extension of nurse prescribing to include specialist nurse prescribing (later called registered nurse prescribing in primary and specialty teams) and community nurse prescribing (later called registered nurse prescribing in community health). There were some areas within the proposals where there was less agreement and divergent views, largely related to the lists of medicines but also to the proposed qualification and training for community nurse prescribing. A summary of the 2013 RNP key proposals consultation feedback can be found in Appendix One.

In 2016, the Medicines (Designated Prescriber – Registered Nurses) Regulations[5] were passed. These regulations gave registered nurses who met the specified requirements for qualifications, training and competence, authorisation to prescribe specified medicines as a designated prescriber. The regulations also revoked the Medicines (Designated Prescriber – Registered Nurses Practising in Diabetes Health) Regulations 2011. The 2016 regulations required the medicines identified for prescription by registered nurses to be specified by the Director-General and notified by gazette under section 105(5A) of the Medicines Act (resulting in the 'list' RN prescribers currently prescribe from). The Council was required to specify the required qualifications and training by gazette notice and authorise the prescriber, once they had demonstrated to the satisfaction of the Council that they were sufficiently knowledgeable to safely prescribe the specified prescribed medicines.

In August 2016, The Nursing Council published a gazette notice outlining the requirements for registered nurses practising in collaborative primary health and specialty teams who wished to prescribe specified prescription medicines.[6] This notice was followed in September 2016 by the first gazetted list of specified medicines these nurses could prescribe.[7]

In 2017, Nursing Council published a gazette notice outlining the requirements for registered nurses practising in community health services who wished to prescribe specified medicines along with a, much more limited, subset of specified medicines listed on the Nursing Council website.[8] The gazetted list of medicines was updated in 2022 and again in 2024.[9]

There were two other minor changes in 2022. The need for yearly recertification for registered nurses prescribing in primary and specialty teams was moved to three yearly to align with NP and registered nurse prescribing in community health. The requirement for RN prescribers to work under clinical supervision for their first year of practice was also removed.

Recertification of registered nurses prescribing in primary health and specialty teams is managed by the Council and recertification of registered nurses prescribing in community health is managed by the education provider. This regulatory regime continues to the present day.

Current forms of RN prescribing

There are three levels of prescribing authority for nurses:[10]

1. RN prescribers in primary health and specialty teams are designated to prescribe from a schedule of common medicines for common and long-term conditions.
2. RN prescribers in community health are designated to prescribe a limited subset of medicines from the above specified schedule.
3. NPs have a distinct scope of practice to registered nurses and are authorised to prescribe nearly any prescription medicines (out of scope for this paper).

There are also three further forms of authorisation that registered nurses can obtain to supply medicines:

- for the emergency contraceptive pill
- for hepatitis C medicines (both authorised by Nursing Council)and
- for vaccination (authorised by the Director General of Health or a local Medical Officer of Health).

1. RN prescribing in primary health and specialty teams

Registered nurses prescribing in primary and specialty teams prescribe from a list of medicines for common and long-term conditions. Nurses must be a part of a collaborative team so the nurse can consult a medical practitioner or mātanga tapuhi nurse practitioner if the patient's health concerns are more complex than their level of competence, experience and education. RNs approved to prescribe in primary health and specialty teams have this authorisation included in the public information section of the register.

Guidance for employers and nurses is available on the Nursing Council website.[11] The guidance provides advice on maintaining safe prescribing practice and legal limitations for RN prescribing.

Requirements

Registered nurses who wish to prescribe in primary health and speciality teams are required to have:

- a minimum of three years' full-time practice in the area they intend to prescribe in with at least one year of the total practice in New Zealand or a similar healthcare context
- completed a Council-approved postgraduate diploma in registered nurse prescribing for long-term and common conditions, or equivalent as assessed by the Council
- completed a practicum with an authorised prescriber (senior doctor or mātanga tapuhi nurse practitioner), which demonstrates knowledge to safely prescribe specified prescription medicines and knowledge of the regulatory framework for prescribing
- a satisfactory assessment of the competencies for nurse prescribers completed by the prescribing mentor (authorised prescriber)
- a RNP role within a collaborative team which includes an authorised prescriber who will continue to provide mentorship and support for prescribing practice.

The programme outcomes for the postgraduate diploma in registered nurse prescribing for long-term and common conditions are embedded in the education programme standards for mātanga tapuhi nurse practitioner master's programmes. Section 3 of the standards describes the specific programme content, structure and curriculum for the preparation of RN prescriber and NP candidates with section 3.1 specifically stating the NP programme includes the postgraduate diploma in registered nurse prescribing. Section 3.10 describes the specific requirements for the postgraduate diploma.[12] This means the postgraduate diploma may be credited to a mātanga tapuhi nurse practitioner master's programme.

2. RN prescribing in community health

RNs practising in community health settings wishing to prescribe must complete a work-based education programme prior to applying to the Council for prescribing authority. This authority enables the RN to prescribe a limited number of medicines for minor ailments and illnesses in normally healthy people without significant health problems. RNs prescribing in community health are expected to work in a collaborative team, use decision support tools, be familiar with current best practice information and have the support of colleagues. RNs approved to prescribe in community health have this authorisation included in the public information section of the register. Guidance on RN prescribing in community health can be found on the Council website.[13]

Registered nurses are only able to apply for this prescribing authority if they are part of an approved programme. Approved programmes are:

- Auckland Metro region
- Sexual Wellbeing Aotearoa (formerly Family Planning)
- Midlands Collaborative
- MidCentral
- Hawke's Bay
- Te Waipounamu (formerly South Island Alliance)
- Capital, Coast and Hutt Valley district with the Wairarapa district.

Requirements

- A minimum of three years' clinical experience with at least one year in the area of prescribing practice in New Zealand or in a country with a similar healthcare context.
- Completed a Council-approved recertification programme for registered nurse prescribing in community health.
- Completed a period of supervised practice with a designated authorised prescriber (a medical practitioner or mātanga tapuhi nurse practitioner) as part of the recertification programme.
- Prescribe from a limited list of medicines within their competence and area of practice and meet ongoing competence requirements for prescribing.

3. Diabetes

Registered nurses who prescribe in diabetes health can prescribe pharmacy-only and general sale items, and a limited set of diabetes-specific medicines. The pathway to this type of prescribing was closed in 2017 as it has been superseded by other types of prescribing.

4. Emergency contraceptive pill (ECP)

Registered nurses who are practising within the specific area of sexual and reproductive health may apply to the Nursing Council for authorisation to supply the emergency contraceptive pill (ECP). Registered nurses approved to supply the ECP have this authorisation included in the public information section of the register.

Requirements

Registered nurses must meet the following criteria to apply for authorisation to supply the ECP:

- a current annual practising certificate (APC)

- evidence that the applicant has completed an approved training course with at least three hours covering the ECP completed within the last five years
- twelve months or more experience in a relevant area of practice. Nurses employed by Sexual Health Aotearoa New Zealand may apply before 12 months and provide an attestation by a senior colleague that they have competently managed, documented and logged 20 ECP consultations.

5. Hepatitis C medication supply

Registered nurses who are practising within the area of Hepatitis C screening and treatment may apply to the Council for authorisation to supply the Hepatitis C medication. Registered nurses approved to supply the Hepatitis C medication will have this authorisation included in their scope of practice and recorded in the public information section of the register.

Requirements

Registered nurses must meet the following criteria to apply for authorisation to supply Hepatitis C medication:

- a current annual practising certificate (APC)
- evidence that the applicant has completed an approved training course within the last five years
- be providing care for health consumers with Hepatitis C.

6. Authorised vaccinators

Although not regulated by the Council, authorised vaccinators are health professionals (the majority of whom are registered nurses) who are part of an approved immunisation programme who can legally administer vaccines to all ages without a prescription or standing order[ii]. Fully authorised vaccinators are authorised under regulation 44 A (2) of the Medicines Regulations 1984 by the Director-General of Health or a Medical Officer of Health.[14] This regulation stipulates that the person seeking approval must apply in writing to the Director-General or a Medical Officer of Health and provide the documentary evidence outlined in Appendix four of the Immunisation Handbook.[15]

[ii] A standing order is a written instruction issued by an authorised prescriber to authorise a person or class of people who do not have prescribing rights, e.g. registered nurses, to administer or supply specified medicines and some controlled drugs.

Upcoming legislative changes that will impact on the current context

In July 2023, the then Labour government passed into law the Therapeutic Products Act to replace the outdated Medicines Act 1981, with enactment scheduled for 2026. In December 2024, the now National Coalition government repealed the Therapeutic Products Act and has begun working on a new Medical Products Bill. While work on the new bill continues, the Medicines Act 1981 remains in place. The new bill is intended to provide modern, risk-proportionate regulation of medicines and medical devices ('medical products'), with the intention of supporting improved health outcomes for all New Zealanders by enabling timely access to safe, high quality, and effective medical products. The bill is also intended to support patients, practitioners and industry.

Cabinet materials relating to the new Medical Products Bill and the standalone Natural Health Products Bill have been published on the Ministry of Health website.[16] Documents relating to the Therapeutic Products Act and its repeal can also be found on the Ministry of Health website.[17]

In committing to develop the Medical Products Bill, Cabinet agreed the legislation should be harmonised with international good practice and support innovation, competition, economic growth and exports in a way that maintains New Zealand's reputation as a producer of high-quality products. The Government intends that the Medical Products Bill be passed in 2026 or 2027 and come into effect around 2028 or 2029. The bill will include provisions to give existing products time to transition to the new regime. Discussions on the bill have, to date, indicated support for expanding prescribing to new groups of practitioners and the development of new scopes of practice to support the expansion.

Consultation on the bill provides an opportunity to work with the Government and Ministry of Health to support development of enabling legislation for RN prescribing.

Workforce

At the end of June 2025, there were 1,584 RNs with some form of prescribing rights, excluding mātanga tapuhi nurse practitioners and authorised vaccinators (who the Council does not regulate and does not keep statistics on). This compares to 1,374 at the same time last year, an increase of 210 nurses or 15.28%. Of these nurses, 655 were RN prescribers in primary health and specialty teams, 656 were RN prescribers in community health, 43 were RN prescribers in diabetes, 213 were registered nurses who

were only able to supply the emergency contraceptive pill, and 17 were registered nurses who had authorisation to supply Hepatitis C medication.[18]

Nurse prescribers (including nurse practitioners) were the largest non-medical prescriber contributors to all prescriptions (medical and non-medical) dispensed between 2016 and 2020, writing 1.4% of all prescriptions.[19] The most commonly prescribed medicines by nurse prescribers were analgesics, followed by antibacterials.[20] This aligns with international studies.[21] Proportionately, the number of non-medical prescriptions dispensed (10,274,324) remains low compared to medical prescriptions (358,137,624).[22] Sixty percent of prescriptions written by nurse prescribers were for women, and nurse prescribers were more likely to prescribe for patients who identified as Māori and for people living in more deprived areas than other non-medical prescribers.[23] However, they were less likely to prescribe for patients of Pacific ethnicity than other non-medical providers.[24]

In summary, the data shows that:

- numbers of RN prescribers are increasing across all forms of registered nurse prescribing (except diabetes)
- most RN prescribers are clinically very experienced prior to taking up prescribing education
- while we will continue to increase numbers of Māori RN prescribers and Pacific RN prescribers, the numbers are proportionately strong
- most RN prescribers work in some type of community setting
- men and non-binary people are under-represented in RN prescriber figures.

Data

Table 1 presents the total number of RNs with prescribing rights at the end of each quarter, by the type of rights they held. RNs with prescribing rights represented 1.8% of all nurses with an APC at the end of the last quarter. This is the same as a year ago.

Table 1: Nurses with prescribing rights, by quarter (30 June 2025)

	June 2024	September 2024	December 2024	March 2025	June 2025
RN prescriber - primary health and specialty teams	586	597	630	664	655
RN prescriber - community health	492	518	588	613	656
RN prescriber - diabetes	45	45	43	43	43
Total	**1,123**	**1,160**	**1,261**	**1,320**	**1354**

Table 2 shows the geographic region of employment/practice for the year ended 31st March 2025. The table shows that RN prescribing is widely distributed across all areas of Aotearoa New Zealand except the West Coast where there are few RN prescribers.

Table 2: Geographic region of employment/practice 31 March 2025

Region of practice	Primary health and specialty teams prescribing	Community health prescribing	Diabetes prescribing	Total Number of prescribers	Percentage of prescribers
Auckland	150	173	12	**335**	**25.5%**
Bay of Plenty	51	39	2	**92**	**7.0%**
Canterbury	71	21	2	**94**	**7.2%**
Hawkes Bay	49	40	2	**91**	**6.9%**
Manawatū-Whanganui	64	36	5	**105**	**8.0%**
Nelson - Marlborough	19	15	-	**34**	**2.6%**
Northland	31	5	3	**39**	**3.0%**
Otago	26	42	2	**70**	**5.3%**
Southland	11	19	-	**30**	**2.3%**
Tairāwhiti	11	27	1	**39**	**3.0%**
Taranaki	11	33	-	**44**	**3.4%**
Waikato	71	85	6	**162**	**12.3%**
Wellington	68	53	8	**129**	**9.8%**
West Coast	6	-	-	**6**	**0.5%**
New Zealand wide	2	1	-	**3**	**0.2%**
Not stated	*18*	*21*	-	***39***	***3.0%***
Total active registered nurse prescr	**659**	**610**	**43**	**1312**	**100.0%**

Table 3 shows the practice area of RN prescribers. For RN prescribers in primary health and specialty teams, the largest group of RN prescribers work in primary health care and practice nursing settings. Many of the other practice areas also reflect community type work, for example family planning/sexual health and aged care. The second largest individual group is medical. This is likely to reflect diabetes nurse prescribing practice where RN prescribers have been present since 2011. RN prescribers in community health, work predominantly in practice nursing and primary health care with other community-based settings comprising the remainder. This is reflective of the parameters of this type of RN prescriber. Of note is the low numbers of RN prescribers in mental health, aged care and district nursing/home care.

NB Nurses can report up to two practice areas.

Table 3: Practice area (as at March 31 2025)

Practice area	Primary health and specialty teams prescribing	Community health prescribing	Diabetes prescribing	Total Number of prescribers	Percentage of prescribers
Addiction services	1	1	-	**2**	**0.2%**
Aged care	18	5	-	**23**	**1.8%**
Assessment and rehabilitation	8	4	-	**12**	**0.9%**
Child health including neonatology	31	18	1	**50**	**3.8%**
Cosmetic/aesthetic nursing	2	2	-	**4**	**0.3%**
District nursing/home care	6	10	1	**17**	**1.3%**
Emergency and trauma	36	27	-	**63**	**4.8%**
Intensive care/cardiac care	22	-	-	**22**	**1.7%**
Medical	117	10	22	**149**	**11.4%**
Mental health (community)	5	1	-	**6**	**0.5%**
Mental health (inpatients)	1	-	-	**1**	**0.1%**
Nursing administration and management	6	11	2	**19**	**1.4%**
Nursing professional advice/policy development	3	2	-	**5**	**0.4%**
Nursing research	1	-	-	**1**	**0.1%**
Nursing tertiary education	21	12	6	**39**	**3.0%**
Obstetrics/maternity	2	4	-	**6**	**0.5%**
Occupational health	1	5	-	**6**	**0.5%**
Oncology	22	-	-	**22**	**1.7%**
Palliative care	8	3	-	**11**	**0.8%**
Perioperative care (theatre)	4	2	-	**6**	**0.5%**
Practice nursing	45	75	2	**122**	**9.3%**
Primary healthcare (including practice nursing)	265	337	5	**607**	**46.3%**
Public health	2	32	-	**34**	**2.6%**
School health	1	25	-	**26**	**2.0%**
Sexual and reproductive health	23	42	-	**65**	**5.0%**
Surgical	17	4	-	**21**	**1.6%**
Telehealth	2	-	-	**2**	**0.2%**
Youth health	4	22	-	**26**	**2.0%**
Other area	41	16	6	**63**	**4.8%**
Not stated	*6*	*9*	-	***15***	***1.1%***
Total active registered nurse prescribers	**659**	**610**	**43**	**1312**	**100.0%**

Table 4 shows RN prescribers by ethnicity for the year ending March 31st 2025. Proportionately, 65.8% of RN prescribers are NZ European (down from 67.9% in 2024) compared with 49% of the RN workforce as a whole, 13.3% are Māori (up from 12.1% in 2024) compared with approximately 7% in the RN workforce as a whole, and 5.3% (up from 4.4% in 2024) have listed a Pacific ethnicity compared with 4% of the RN workforce as a whole.

Table 4: Ethnicity of RN prescribers (as at March 31st 2025)

Ethnicity	Primary health and specialty teams prescribing	Community health prescribing	Diabetes prescribing	Total Number of prescribers	Percentage of prescribers
African	4	2	1	**7**	**0.5%**
Chinese	30	16	-	**46**	**3.5%**
Cook Island Māori	2	6	-	**8**	**0.6%**
Fijian	8	12	1	**21**	**1.6%**
Filipino	35	12	-	**47**	**3.6%**
Indian	39	23	-	**62**	**4.7%**
Niuean	-	5	-	**5**	**0.4%**
NZ European	427	409	27	**863**	**65.8%**
NZ Māori	83	86	6	**175**	**13.3%**
Other Asian	7	8	1	**16**	**1.2%**
Other European	17	27	5	**49**	**3.7%**
Other European - Australian	1	8	-	**9**	**0.7%**
Other European - British and Irish	41	37	7	**85**	**6.5%**
Other European - Dutch	10	1	-	**11**	**0.8%**
Other European - German	3	1	-	**4**	**0.3%**
Other Pacific Peoples	2	1	-	**3**	**0.2%**
Samoan	6	11	-	**17**	**1.3%**
South East Asian	3	1	1	**5**	**0.4%**
Tokelauan	-	1	1	**2**	**0.2%**
Tongan	4	8	1	**13**	**1.0%**
Other ethnicity	20	18	5	**43**	**3.3%**
Not stated	-	-	*1*	***1***	***0.1%***
Total active registered nurse prescribers	**659**	**610**	**43**	**1312**	**100.0%**

Table 5 shows the employment setting of RN prescribers, with most RN prescribers working within non-Te Whatu Ora providers and predominantly with community employers. Of note, is the larger number of RN prescribers in community health in Māori health service providers than RN prescribers in primary and specialty teams.

Table 5: Employment settings of RN prescribers (as at March 31st 2025)

Employment setting	Primary health and specialty teams prescribing	Community health prescribing	Diabetes prescribing	Total Number of prescribers	Percentage of prescribers
Educational institution	12	14	-	**26**	**2.0%**
Government agency (e.g. Ministry of Health, ACC, Corrections, Defence)	12	2	1	**15**	**1.1%**
Health NZ Te Whatu Ora - clinical (community)	64	60	12	**136**	**10.4%**
Health NZ Te Whatu Ora - clinical (hospital)	211	35	20	**266**	**20.3%**
Health NZ Te Whatu Ora - non-clinical/other	-	1	-	**1**	**0.1%**
Māori health service provider	13	41	-	**54**	**4.1%**
Nursing agency	4	5	-	**9**	**0.7%**
Pacific health service provider	-	3	-	**3**	**0.2%**
Primary healthcare	327	462	11	**800**	**61.0%**
Private hospital (i.e. non Health NZ Te Whatu Ora)	16	1	1	**18**	**1.4%**
Rest home/residential care	14	6	-	**20**	**1.5%**
Rural	13	15	1	**29**	**2.2%**
Self employed	10	8	1	**19**	**1.4%**
Other setting	21	15	1	**37**	**2.8%**
Not Stated	*3*	*5*	-	***8***	***0.6%***
Total active registered nurse prescribers	**659**	**610**	**43**	**1312**	**100.0%**

NB. Nurses can list more than one employment setting.

Table 6 shows the gender of RN prescribers for the year ending March 31st 2025. There are proportionately more female than male RN prescribers compared to the overall population of RNs where males comprise approximately 10% of the workforce. Nurses who reported another gender are included in total figures.

Table 6: Gender of RN prescribers (as at March 31st 2025)

Gender	Primary health and specialty teams prescribing	Community health prescribing	Diabetes prescribing	Total Number of prescribers	Percentage of prescribers
Female	620	595	42	**1257**	**95.8%**
Male	38	14	-	**52**	**4.0%**
Total active registered nurse prescribers	**659**	**610**	**43**	**1312**	**100.0%**

Table 7 shows the years since registration of RN prescribers. The bulk of RN prescribers have been practising for over 15 years although numbers of RN prescribers who have been practising for less than 10 years make up the next largest cohort.

Table 7: Years since registration of RN prescribers (as at March 31st 2025)

Years since registration	Primary health and specialty teams prescribing	Community health prescribing	Diabetes prescribing	Total Number of prescribers	Percentage of prescribers
10 years or fewer	170	173	-	**343**	**26.1%**
11-15 years	136	114	2	**252**	**19.2%**
Over 15 years	353	323	41	**717**	**54.6%**
Total active registered nurse prescribers	**659**	**610**	**43**	**1312**	**100.0%**

Table 8 shows the number of years since gaining prescribing authorisation. The figures reflect a rapidly growing workforce of RN prescribers over the past three years.

Table 8: Years since gaining prescribing authorisation (as at March 31st 2025)

Years since gaining authorisation	Primary health and specialty teams prescribing	Community health prescribing	Diabetes prescribing	Total Number of prescribers	Percentage of prescribers
Less than one year	142	175	-	**317**	**24.2%**
1	121	170	-	**291**	**22.2%**
2	105	96	-	**201**	**15.3%**
3	82	99	-	**181**	**13.8%**
4	71	37	-	**108**	**8.2%**
5	69	5	-	**74**	**5.6%**
6	40	-	-	**40**	**3.0%**
7	22	28	19	**69**	**5.3%**
8	7	-	5	**12**	**0.9%**
9	-	-	5	**5**	**0.4%**
10 or more years	-	-	14	**14**	**1.1%**
Total active registered nurse prescribers	**659**	**610**	**43**	**1312**	**100.0%**

Tables 9, 10 and 11 show the year-on-year increase in registered nurse prescribers from 2016 to the present day. Between 2021-2025, registered nurse prescribers in primary health and specialty teams have increased by 363 nurses or 121% (from 301 to 664). Registered nurse prescribers in community health have increased by 530 nurses or 639% (from 83 to 613).

Table 9: Total numbers of prescribers each year as at end June

Authorisation	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Primary health and specialty teams prescribing	0	12	66	135	215	301	368	435	586	664
Community health prescribing	0	0	56	56	60	83	199	311	467	613

Table 10: Year-on-year increase RN prescribers in primary health and specialty teams as at end June

Primary health and specialty teams prescribing	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Number of prescribers	0	12	66	135	215	301	368	435	586	664
Increase on previous year	-	12	54	69	80	86	67	67	151	78
Percentage increase on previous year	-	-	450%	105%	59%	40%	22%	18%	35%	13%

Table 11: Year-on-year increase RN prescribers in community health

Community health prescribing	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Number of prescribers	0	0	56	56	60	83	199	311	467	613
Increase on previous year	-	0	56	0	4	23	116	112	156	146
Percentage increase on previous year	-	-	-	0%	7%	38%	140%	56%	50%	31%

International context of RN prescribing

International comparisons of nurse prescribing have identified considerable variation in the practice of nurse prescribing in different countries. [25, 26, 27] The legal, educational and organisational conditions under which nurses prescribe medicines vary considerably between countries; from situations where nurses prescribe independently to situations in which prescribing by nurses is only allowed under strict conditions and the supervision of physicians. The International Council of Nurses (ICN) describe several different types of prescribing and note the differences between countries reflect the diversity of healthcare systems, the maturity of nursing within the system and the role of government regulation and influence over policy.

Table 12 provides an overview of the different types of prescribing internationally, based on the ICN's descriptions.

Table 12: Types of nurse prescribing[28]

Type	Description	Examples of countries who use this type of prescribing
Independent	Prescriber is fully responsible and accountable for the clinical assessment, diagnosis and treatment decisions for a patient including issuing of a prescription. Prescribers in this category can usually prescribe from a full or limited formulary. Mātanga tapuhi nurse practitioners in Aotearoa New Zealand are an example of an independent prescriber.	US, UK, NZ, Finland, Switzerland, Canada, Ireland.
Supplementary, dependent or collaborative	The prescriber works closely with an independent prescriber, either in a collaborative relationship where there is access to immediate support available for prescribing practice (such as designated nurse prescribers in Aotearoa New Zealand) or as a supplementary prescriber who does not carry out the initial assessment and diagnosis, and consults with the independent	NZ, UK, Australia, the Netherlands.

	prescriber before issuing a prescription. Most prescribe from a limited list or formulary.	
Prescribing via a structured prescribing agreement (protocol)	Designed for a specific group of patients who have a particular condition. Patient Group Directives in the UK are an example of this. Standing orders are a further example although it is very clear that this is not considered prescribing in Aotearoa New Zealand.	UK, NZ.
Prescribing to administer	Delegated authority under a pre-approved protocol and conditions for immediate medication administration e.g. as part of an emergency response or for vaccination.	NZ, UK.

In countries such as Finland, Switzerland, Australia, the United States and Canada, nurse prescribing is restricted to "advanced practice nurses"; that is nurses in a recognised role such as mātanga tapuhi nurse practitioner or clinical nurse specialist with postgraduate qualifications – usually at a master's level. The International Council of Nurses defines an 'advanced practice nurse' as a '*generalist or specialised nurse who has acquired through additional graduate education (minimum of a master's degree), the expert knowledge base, complex decision-making skills and clinical competencies for Advanced Nursing Practice*'.[29] Nurses in this category are generally able to prescribe most, if not all, medicines available in that country.[30] [31]

In other countries such as the UK, Ireland, the Netherlands, Sweden, Denmark, Aotearoa New Zealand and, recently, Australia, nurse prescribing has taken different forms ranging from independent prescribing in the UK (graduate qualification and no or some limitations to medicines) to supplementary prescribing (graduate qualification with prescribing practice overseen by a medical or nurse practitioner). Most countries sit somewhere between these two approaches, enabling nurse prescribing for nurses who have completed some type of graduate or postgraduate qualification (not master's) and limited by the types of medicines that are able to be prescribed.[32]

Australian nurse prescribing has been largely restricted to master's prepared nurse practitioners although registered nurses can initiate (supply) some medicines in some states.[33] Health Workforce Australia has long been advocating for the development of a national approach and implementation plan for non-medical prescribing and in December 2024, the Australian government approved new accreditation standards for registered nurse prescribing developed by the Australian Nursing and Midwifery Accreditation Council (ANMAC). The new standards enable suitably educated and qualified RNs to prescribe Schedule 2, 3, 4 and 8 medicines[34] in partnership with an authorised health practitioner under a prescribing agreement.[35]

The Australian Registered Nurse Prescribing Accreditation Standards are used to assess education programmes leading to the 'endorsement for scheduled medicines –

designated registered nurse prescriber' with the Nursing and Midwifery Board of Australia (NMBA). Registered nurses must complete a programme of study, accredited by ANMAC and approved by NMBA, to be eligible to apply for the endorsement with NMBA. As of August 2025, there were no RNs in Australia qualified under the new regulations.

Nurse prescribing has a long history in the UK, stretching back some 30-plus years. In 2023, the UK Nursing and Midwifery Council removed some of the requirements for the length of time a nurse must be in practice prior to commencing a prescribing course, with an expectation that nurses would be 'prescribing ready' on graduation from an undergraduate programme.[36] [37] There are two levels of prescribing in the UK - the first is the community practitioner nurse who is able to prescribe from a limited community formula (Nurse Prescribers Formulary for Community Practitioners in the British National Formulary). Nurses complete either a v100 or V150 course depending on whether they are training to become a specialist nurse or not. There is no requirement to be a specialist nurse in order to be able to prescribe. There is no requirement to have been in practice for any particular length of time to be eligible to undertake this course. The education establishment where the nurse applies to undertake the relevant course decides if the nurse is ready.[38]

The second level of nurse prescribing in the UK is the independent prescriber. To prescribe as an independent prescriber, the nurse must undertake a V300 course (of which some credits may be credited toward a master's degree but the course is not necessarily a full postgraduate certificate or diploma). The course itself comprises 78 hours of taught study with 90 hours of learning in practice. In this level of prescribing, the nurse must have completed one year of practice before applying, and once qualified can prescribe any medicine on the British Formulary. It is useful to note this course is also completed by other non-medical professionals. Ireland and Switzerland have also expanded access for nurse prescribers to their full formularies although do appear to require a postgraduate qualification.[39]

Prescribing in the United States is largely restricted to advanced practice registered nurses (nurse practitioners, nurse anaesthetists, nurse midwives and clinical nurse specialists) although the level of prescriptive authority depends on each state's legislation. In Canada, prescribing is restricted to nurse practitioners with varying formularies depending on province.

Appendix two shows a selection of international registered nurse prescriber requirements.

Non-medical prescribers in Aotearoa New Zealand

Non-medical prescribing is undertaken by a selection of health practitioner groups in Aotearoa New Zealand. Registered midwives and optometrists are considered authorised prescribers (as are medical practitioners, nurse practitioners and dentists) with the ability to prescribe any medicine within their scope of practice. Midwives, for example, can prescribe any medicine as authorised prescribers but the limits as to when a midwife can prescribe are set out in Section 39 (1)(a)(i) and (ii) of the Medicines Regulations 1984. This regulation determines that authorised prescribers may only prescribe a medicine if the authorised prescriber is doing so:

> "(i) for the treatment of a patient under the authorised prescriber's care and
>
> (ii) within, and in accordance with all conditions (if any) stated in, the authorised prescriber's scope of practice".

The Midwifery Council has gazetted the midwifery scope of practice as the provision of 'culturally and clinically safe care, in any setting, for women/persons and whānau who are planning a pregnancy, pregnant, birthing, and postnatal'.[40]

Pharmacists who meet specified requirements for competence, qualifications and training can become pharmacist prescribers as per the Medicines (Designated Pharmacist Prescribers) Regulations 2013.[41] Pharmacist prescribers prescribe from a list with 1,722 medicines (significantly larger than the current gazetted lists for RN designated prescribers which have a total of 248 medicines on them – including controlled drugs). Pharmacist prescribers (there are currently over 100 in New Zealand) are required to have completed three years of recent and appropriate post-registration experience working in a collaborative health team environment, hold an approved postgraduate certificate in prescribing, have submitted a practice plan which outlines the area of practice and have agreed clinical governance arrangements in place. [42]

In light of an anticipated rapid increase in the numbers of pharmacist prescribers, the Pharmacy Council is currently reviewing the pharmacist prescriber regulatory regime. The review aims to '…prompt further sector-wide discussions, consider pending changes that will support pharmacist prescribers' practice, and then where sensible, identify changes to keep regulation proportionate for managing the risk to patients' safety.'[43] The Pharmacy Council notes concern regarding the level of support available for new pharmacist prescribers and the potential for changing some of the requirements around the practice plan for experienced pharmacist prescribers. The practice plan is a requirement for authorisation as a pharmacist prescriber and summarises the individual's prescribing practice. The Pharmacy Council assesses and provides feedback on the initial plan and the pharmacist must submit the plan on renewal of their

practising certificate. Any updates to the plan (that has been agreed with the clinical lead) are submitted retrospectively to the Pharmacy Council on renewal of their annual practising certificate. Pharmacist prescribers note the plan can be onerous so the review provides some options for addressing this.[44]

Registered dietitians who have completed either an approved master's degree or the Dietitian's Board prescriber training course can prescribe specified special foods and approved nutrition-related medicines,[45] and from a limited list of other medicines and appliances.[46] Registered dietitians who prescribe must have an ongoing supervised prescribing relationship with a registered prescriber, include prescribing and prescribing-related developments as part of their professional development, undertake an annual practice review of their prescribing and complete an annual prescriber update online.[47]

Podiatrists who have undertaken appropriate training were granted designated prescribing authority in 2025 under the 'Medicines (Designated Prescriber-Podiatrist) Regulations 2025'. Podiatrists can prescribe from a limited list of medicines relevant to their scope of practice. The Podiatrist Board has adopted the Aotearoa shared '*Principles for quality and safe prescribing practice'* to guide the development of their own standards.

Paramedics are also interested in developing prescribing practice and have initiated conversations with their own regulatory bodies.

An examination of non-medical prescribing trends in New Zealand primary care and community settings from 2016 to 2020 found that non-medical prescriptions increased from 1.8% of all prescriptions in 2016 to 14.4% in 2019.[48] Nurse prescribers were the largest non-medical prescriber contributors to all prescriptions followed by dentists, midwives and pharmacist prescribers. Optometrists and dietitians were the smallest contributors.[49] The study did not distinguish between RN prescribers and NPs, and noted that while non-medical prescribers were growing in number, their contribution to overall prescribing practice remained low.[50]

Evidence associated with RN prescribing

High level summary of literature review

- Nurse prescribing is safe and effective.
- There have been almost no complaints to NCNZ about nurse prescribing practice since inception. None have progressed to the HDC or HPDT.

- RN prescribing empowers RNs through increasing self-efficacy and promoting professional accountability.
- RN prescribing is cost effective but further study is needed to consider costs of training and implementation.
- It is difficult in some studies to determine the contributions of other team members to prescribing outcomes.
- RN prescribing requires commitment from policy makers and government.
- Protocols and formularies can help all prescribers with decision-making; however, they can also result in a decrease in opportunities to develop prescribing practice so do need to be used with caution.[51].
- Organisational buy-in, support and confidence in RN prescribing is essential with commitment to good clinical governance, clear policies and workforce planning in place.
- RN prescribing provides opportunities to consider new models of care and alternative service delivery approaches.
- Trust between prescribing professions is essential and engendered by activities such as interprofessional education of prescribers, use of clinical champions, socialising RN prescribing in the organisation, educating existing prescribers to the nature and extent of RN prescribing, having formal structures around case review and implementing generic prescribing frameworks.
- Continuing professional development is important in maintaining RN prescriber confidence in their prescribing abilities.
- RN prescribers in Aotearoa New Zealand are limited by the current use of a list of medicines to regulate prescribing practice.
- Collaborative relationships and joint decision-making regarding prescribing practice is beneficial for patients and for RN prescribers, but not always easily enacted in the practice context.
- RN prescribers tend to not receive pay increases once they gain their prescribing authority even though they can experience an increased workload, increased responsibility and increased accountability.
- A lack of individualised data on nurse prescribing practice in Aotearoa New Zealand limits the ability to fully analyse patterns and practices of prescribing activity.

Outcomes

There is substantial and growing evidence that nurse prescribing is safe and effective. In general, studies find that nurse prescribing is as effective as usual care, delivering comparable outcomes to medical prescribing.[52] [53] [54] [55] In some circumstances, nurse prescribing has demonstrated better outcomes than medical prescribing: for example, a Cochrane Collaboration systematic review identified improved adherence to medication regimes in the non-medical prescribing group[56] with other studies identifying higher

patient satisfaction in a range of areas including treatment confidence, practical advice and coping support.[57] [58] Further, nurse prescribing has been shown to improve access to medicines (in Aotearoa New Zealand, this is particularly the case for Māori, and those living in high deprivation and rural areas).[59] [60] [61] [62] [63] Nurses are also shown to be cautious prescribers and practice well within scope[64] with some evidence of fewer admissions to hospital after a prescribing episode with a nurse than with a doctor[65] The Council has had almost no medico-legal complaints regarding nurse prescribers since their inception. No complaints have gone on to the Health Practitioners Disciplinary Tribunal (HPDT) or Health and Disability Commissioner (HDC).

Nurses who prescribe also report benefits for themselves, their practice and people who receive a prescription from a nurse.[66] [67] [68] [69] Cleary notes the change to become a prescriber positively influenced how nurse prescribers in mental health settings perceived their professional selves and empowered them to practise more effectively with patients.[70] While some studies have found some nurse prescribers perceive the responsibility and accountability of prescribing negatively due to concern of making an error,[71] other studies have found it more common for nurses to welcome the responsibility, with nurse prescribing promoting professional accountability and improving patient safety as a result.[72] [73] [74] [75] Participants in Pearson and colleagues study believe the added responsibility and accountability results in more thorough education and follow up of patients.[76] Further, nurse prescribers believe their prescribing practice allows more comprehensive assessment and treatment of patients, reduces waiting times, improves continuity of care and minimises patient costs.[77] [78] [79]

Outcomes in relation to cost have also been examined in the literature with some finding the cost-effectiveness of nurse prescribing to be equivalent to, or better than that of medical prescribing,[80] [81] [82] although the cost benefits of service efficiency and streamlining of patients has been less well explored with recommendations for further studies to examine resource use and economic outcomes.[83] [84] Costs of training and renumeration for nurse prescribers have also been explored with implementation of new models considered expensive and a lack of financial incentives for nurses to complete training considered a barrier to undertaking training.[85]

Challenges and facilitators

A number of studies have explored the challenges of non-medical prescribing. For example, Weeks et al's systematic review, while finding good outcomes from non-medical prescribing, also identified high bias, poor definition of prescribing and difficulty in separating out the contributions of other team members to prescribing outcomes.[86] Further, for nurse prescribing to be effective, it requires clear commitment from policy makers and the government with strategic and workforce planning in place.[87] [88] [89] [90] Other factors, such as the complex needs of many patients and the

implications of antimicrobial resistance, mean non-medical prescribers must have knowledge and support from fellow prescribers, their organisations and from their educational institutions to prescribe responsibly and safely.[91] [92] [93] A lack of protocols to support prescribing decisions, lack of supportive supervision and/or mentoring, fear of making errors and lack of confidence in their own skills have all been identified as factors influencing non-medical prescribers decisions around prescribing.[94] [95] [96] [97] Having in place effective additional training beyond foundational education qualifications prior to prescribing, as well as access to ongoing training in prescribing, are considered essential for ensuring safe prescribing.[98] Several countries have developed national formularies that support rational prescribing practice and prescribing decisions.[99] Formularies are designed to set policies and protocols in relation to drugs and therapeutics and can also be used to assess, teach and guide prescribing practice.[100] For example, the UK uses the British National Formulary[101] and in Aotearoa New Zealand, the New Zealand Formulary (NZF).[102]

Organisational support and confidence in nurse prescribing have been identified as essential for successful implementation.[103] [104] [105] [106] [107] Where these are lacking, nurses are less likely to prescribe and the noted benefits less likely to be achieved.[108] While Creedon and colleagues note that prescribing increases effectiveness and autonomy in practice, issues remain regarding the additional work required to prescribe that often goes unrecognised, and challenges with continuing professional development which in turn affects nurse prescribers confidence to prescribe.[109] [110] Having good clinical governance frameworks, clear policies, good workforce planning in place, recognising that deprescribing, education and titration are equally as important and frequently more time intensive as prescribing, and remunerating prescribers appropriately for their prescribing practice will support nurse prescribing within an organisation.[111] [112] [113] [114] [115]

Norris suggests nurse prescribing offers an opportunity for innovation and thinking beyond traditional models of care delivery, and that organisations can consider alternative approaches to allocating work, and organising space and time, in order to achieve optimal outcomes.[116] However, Hewitt et al note the inability to track individuals in data limits the ability to understand the prescribing practice of nurses in Aotearoa New Zealand, subsequently limiting the ability to better facilitate the use of RNP in the local context.[117]

Navigating professional boundaries was also identified as a challenge for some nurse prescribers, particularly where organisations lacked awareness of the role of the nurse prescriber and were unprepared for the new role.[118] Working with organisations through the use of clinical champions and raising the profile of new roles is considered helpful when new roles are introduced.[119] [120] Changing roles and relationships with

colleagues can also occur with what Cleary describes as '…a shift in the power base among doctors and nurses'.[121] While this was challenging for some medical practitioners, most recognised the competence and credibility of the nurse prescriber.[122] Although recognition of competence is helpful, participants in Wells et al.'s study identified the general practitioner still retained overall responsibility for ensuring a patient's entire medicine regime was safe and effective when more than one prescriber was involved.[123] Nurse prescribers noted having to work hard to establish relationships, having to build trust with their medical and nurse practitioner colleagues and struggling to find appropriate clinical mentors.[124] [125] [126] The challenge of finding appropriate support for those in the community has also been identified by others.[127] Educating others in the organisation, particularly medical practitioners, is considered helpful in facilitating understanding of nurse prescribing and addressing interprofessional challenges.[128] [129] Joint prescribing education has been proposed as an approach to improving interprofessional relationships.[130] [131] Fox et al note that the introduction of a generic competency framework that applies to all prescribing practitioners can also contribute to improving interdisciplinary practice.[132] Aotearoa New Zealand has introduced a set of generic principles for prescribing practice that have been endorsed by all of the regulatory authorities who have prescribing practitioners.[133]

Nurse prescribers in Aotearoa New Zealand describe challenges such as having to prescribe from a limited list or formulary of medicines they consider 'limited and out of date' and being dissatisfied by having to rely on authorised prescribers to prescribe medicines they consider are within their scope of practice but not on 'the list'.[134] Others have also identified that formularies can be cumbersome, require regular review and result in decreased efficiency, cautioning over-reliance on protocols or personal formularies can result in a decrease in opportunities to develop prescribing practice and reduce confidence levels.[135] [136] The 'list' poses particular problems for nurse prescribers in Aotearoa New Zealand due to a range of factors including medicines changed and/or updated frequently with the list becoming outdated soon after publishing. Best practice in the use of medicines can also change frequently with prescribing information associated with the list becoming outdated, while making changes to the list is time-intensive with some changes very nuanced to tertiary and specialty practice. Other challenges described by RN prescribers in Aotearoa New Zealand and internationally include a perceived lack of role recognition, in particular a lack of any pay increase for the extra knowledge and skills they brought to their role, and, as noted earlier, the importance of organisational policies and support frameworks in the workplace to support RN prescribing.[137] [138]

RN prescribers in Aotearoa New Zealand are required to have a collaborative working relationship with a healthcare team with whom they can readily consult.[139] A definition

from the College of Registered Nurses of British Columbia has been used to describe collaboration in the Aotearoa New Zealand context: 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"*.[140] The way in which collaboration and joint decision-making is enacted, however, is dependent on the nature of the interprofessional relationship between the practitioners, with an inherent power differential present between authorised and designated prescribers.[141] Norris notes that just because a RN prescriber has completed the required education, demonstrates competence in prescribing practice and meets the regulatory requirements, does not guarantee they will be able to work collaboratively and engage in shared decision-making with an authorised prescriber, further noting the authorised prescriber controls the opportunity for effective interprofessional practice by enabling or denying the RN prescriber an audience.[142] Norris notes that communication is at the heart of collaboration in prescribing practice and that the physical layout and assignation of office space for prescribers can limit opportunity for true collaborative practice. Others agree, noting that the physical environment can enhance or inhibit good communication between prescribers in general practice.[143] Wells et al.'s study of continuity of care amongst prescribers in general practice found a general lack of clarity around prescriber-related responsibility for decision-making with wide variation in opinion over who holds personal responsibility for a patient.[144] This was attributed to the legislative differences in prescribing rights among participants but is an important factor to consider in ensuring continuity of care and potential power imbalances between prescribers. However, at least early on in the prescribing relationship, the activity undertaken by the RN prescriber to check with an authorised prescriber is also an opportunity to build their own knowledge by drawing on their colleagues' knowledge and build trust with the authorised prescriber.[145] Both Wells et al. and Norris suggest establishing formal opportunities for case review (particularly in general practice) and interprofessional education may alleviate some of these barriers, improve collaborative practice and continuity of care.[146] [147]

Conclusion

RN prescribing in Aotearoa New Zealand New Zealand has been in place for over 10 years. While numbers of RN prescribers have increased slowly and RN prescribing is demonstrated as safe and effective, there is an opportunity to address some of the barriers to RN prescribing that limit opportunities to more fully embed RN prescribing in Aotearoa New Zealand.

Appendix 1. 2013 outcomes from consultation on proposed RN prescribing - summary

Community nurse prescribing

The Council proposed that suitably qualified and experienced registered nurses working in community and outpatient settings[33] be able to prescribe a limited list of medicines to treat minor ailments and infections, and to promote health to some patients. The Council proposed that community nurse prescribing could be included in the registered nurse scope of practice and regulated by Council through using an authorisation or condition on scope of practice. The Council proposed an education programme of six days with three days of prescribing practice with a medical mentor.

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

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

Education and training

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

Specialist nurse prescribing

The Council proposed that registered nurses with advanced skills and knowledge who work in specialty services (e.g. diabetes services) or expert nurses working in general practice teams in the community be authorised to prescribe medicines for patients who have common conditions e.g. asthma, diabetes, hypertension.

The Council proposed two options for how it could regulate specialist nurse prescribing using the scopes of practice provisions under the Act. The first was to introduce a new scope of practice – specialist nurse prescriber. The second option was for specialist nurse prescribing to be included as an authorisation[34] in a registered nurse's scope of practice.

The Council proposed that specialist nurse prescribers complete a postgraduate diploma in specialist nurse prescribing. The programme proposed includes pathophysiology of common conditions, assessment and clinical decision making (diagnosis), pharmacology and prescribing praxis which would include 150 hours of supervised practice with a designated medical prescriber.

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 would enable patients to receive more accessible, timely and convenient care.

Scope of practice or authorisation

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

Education and training

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

Medicines lists

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

Appendix 2. International context of RN prescribing

Country/ Jurisdiction	Level of Qualification	Defined Area of Practice	Length of Study	Entry Requirements	Level of Prescribing Rights
New Zealand	Postgraduate diploma	Primary health and specialty teams	One year full-time study	• RN registration • Three years of full-time equivalent practice in the area where they intend to prescribe with at least one year of the total practice in New Zealand or a similar healthcare context. • Completion of a supervised practicum.	• Designated prescriber: able to prescribe specified medicines. • Works within a collaborative multi-disciplinary team. Must work with an authorised prescriber (NP or doctor) available for consultation. • Able to diagnose and treat common conditions (e.g. asthma, diabetes, hypertension) within a collaborative interdisciplinary team.
New Zealand	Work-based education programme	Community health	Six-seven months part-time learning	• RN registration • Three years' clinical experience with at least one year in area of prescribing practice. • Complete period of supervised practice with authorised prescriber.	• Designated prescriber: able to prescribe specified medicines. • Works within a collaborative multi-disciplinary team. Must work with an authorised prescriber (NP or doctor) available for consultation. Prescribes from a limited list of medicines from which they can prescribe within their competence and area of practice.
Australia	Postgraduate certificate	No	Six months full-time study	• RN registration • Two years' full-time clinical practice.	• Designated prescribers. • Prescribes in partnership (with a NP or doctor) in a prescribing agreement. • Qualified to administer, obtain, possess prescribe, supply and/or use specific medicines.
Ireland	Graduate certificate (Level 7 NZQF)	No	26 weeks full-time study	• RN registration • Three years of clinical experience in the last five years, with one-year full time experience in the specific area of practice. • Employer confirmation and a supervision agreement with a medical practitioner.	Able to prescribe any medication within their scope of practice.

United Kingdom	V100 course (as part of a specialist practitioner qualification) or V150 course for those who wish to prescribe but have not done a specialist course.	Community practitioner nurse	10 weeks plus	No practice time requirement. Education institute decides on whether nurse ready to complete.	Able to prescribe from a limited community formulary (Nurse Prescribers' Formulary for Community Practitioners in the British National Formulary).
United Kingdom	V300 course	Independent prescriber	10 weeks plus	• RN registration for at least one year. • Confirmation that the applicant is capable at a level of proficiency appropriate to the programme and their intended area of prescribing practice in the following areas: - Clinical/health assessment - Diagnostics/care management - Planning and evaluation of care.	• Independent prescriber • Prescribes from the British Formulary.
Finland	45 credits at Master's level	• Public health	One year full-time study	•RN registration • Three years of experience in a prescription-related field within the last five years.	• Restricted right to prescribe medicines used in treatment from pharmacies and from a list published by the Minister of Family Affairs and Social Services. • May prescribe for preventative treatment or in continuation of pharmacotherapy prescribed by a doctor.
The Netherlands	PG course in specialisation with a component of pharmacotherapy	• Diabetes • Oncology • Asthma • COPD			• Designated prescriber • Able to prescribe a limited number of medicines within their speciality after a diagnosis has been made by a physician.
Canada (Ontario)	Graduate certificate or approved programme as part of undergraduate degree (none	No	One year maximum part time or full time	• RN registration • Two years of full time work experience in nursing (graduate certificate) • Complete within 1 calendar year	• Unable to prescribe in hospitals by law • Can only prescribe from a limited number of categories including: - Immunisations - Contraception - Travel health - Topical wound care

	seem to be available)				- Smoking cessation - Anaesthetics - Allergic reaction - OTC medications
Canada (Alberta)	Approved programme (1 for all of Alberta at present)	Yes, specific clinical practice area may be related to the type of care (e.g., wound care), practice setting (e.g., emergency department), specific issue (e.g., sexually transmitted infection), or medical diagnostic grouping (e.g., diabetes or other chronic disease management).	2x 13 week modules online	• RN registration • 3000 clinical hours (750 within specific clinical area for prescribing) • Complete approved program • Clinical support tool specific to the clinical area	• Able to prescribe all schedule I medicines (excluding controlled drugs and substances) – an extensive list of 1,679 prescription and OTC medicines • Able to order relevant diagnostic tests

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[101] BNF UK | NICE British National Formulary

[102] The New Zealand Formulary. The NZF is an independent resource providing healthcare professionals with clinically validated medicines information and guidance on best practice that builds on the New Zealand Universal List of Medicines (ULM) as well as incorporating information from the British National Formulary. The NZF has 16 descriptors or categories based on body systems. Within each category, are sub-categories describing particular conditions.

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