Australian College of Nursing

Australian College of Nursing (ACN) submission to the Nursing and Midwifery Board of Australia (NMBA) on the *Registered Nurse and Midwife prescribing – Discussion Paper (October 2017)*

ACN submission to the NMBA on the Registered Nurse and Midwife prescribing – Discussion Paper (October 2017)

Overarching comment

ACN agrees with the *Registered Nurse / Midwife Prescribing Symposium Final Outcomes Report - May 2017* that there is scope to use registered nursing (RN) skills and knowledge in prescribing medication. In addition to supporting the more efficient use of limited health resources, RN prescribing could reduce demand on traditional prescribers and enhance access to medicines (particularly within disadvantaged, underserviced and harder to reach communities); improve continuity of care; contribute to the quality use of medicines and improved the multidisciplinary management of chronic and complex conditions.[1] This could enhance nurse workforce flexibly and yield additional benefits including better patient experiences, decreased hospital presentations and improve health outcomes.[2][3] Extending prescribing rights to RNs would reveal a host of nurse driven health service options throughout Australia, particularly in the primary health care, aged care and rural and remote settings.

While in support of developing an overarching national RN prescribing framework for future prescribing models, a staged strategic introduction of agreed options should be deliberated. Enabling measures may be required to build confidence in the sector and to garner inter-professional, government and service provider support for the introduction of additional levels of prescribing. These should include greater national standardisation of RN advanced practice nursing (APN) roles and titles and greater national standardisation of Bachelor of Nursing curricula. ACN also supports the need to examine the potential benefits of the four-year Bachelor of Nursing (BN) degree in preparing the nurse workforce to meet future health care needs.

APN Role Standardisation

There is great variation in RN APN roles across the health sector due Australia's jurisdictional health service arrangements.[4,5] There is also a lack of standardised classification of nursing position titles across jurisdictions resulting in poor understanding of the structure of the nurse workforce and APN scope of practice on a national scale.[6] Lack of clarity around these roles has led to nationally inconsistent role development and nurse workforce utilisation.[7] Due to the ad hoc nature of health service planning, there is little standardisation of nomenclature which can lead to nursing role ambiguity, role confusion (including within the health care team) and present barriers to effective nurse workforce distribution and utilisation.[8] APN role standardisation, including the national adoption of the International Council of Nurses' definition of the advanced practice nurse, may better support the introduction of models of RN prescribing and should be examined as part of the NMBA's work to progress a nationally consistent RN prescribing framework.

Review of BN curricula

National evaluation of pharmacology content variation within Bachelor of Nursing curricula may be required to ensure all graduate nurses possess minimum pharmacology knowledge as a baseline for any future prescribing. As noted in the *Registered nurse and midwife prescribing – Discussion paper* (the Discussion Paper*)*, the introduction of RN prescribing would require a review of the undergraduate RN accreditation standards. A core part of this review

---

[1] Australian Government Department of Health, 'Registered Nurse / Midwife Prescribing Symposium: Final Outcomes Report' (2017).
[2] Ibid.
[3] Australian College of Nursing, 'Nurses Are Essential in Health and Aged Care Reform: A White Paper by ACN' (2016) <https://www.acn.edu.au/sites/default/files/advocacy/20160930_nurses_are_essential_to_health_and_aged_care_reform_white_paper_web.pdf>.
[4] Michael Roche et al, 'Domains of Practice and Advanced Practice Nursing in Australia' [2013] *Nursing and Health Sciences,* 15, pp.497-503.
[5] G Gardner et al, 'The Structure of Nursing: A National Examination of Titles and Practice Profiles' [2017] *International Nursing Review*.
[6] G Gardner et al.
[7] Roche et al.
[8] Gardner et al.

should be a comprehensive national assessment of pharmacology course and program variance including (not limited to) subject content, objectives, learning outcomes, theory, practice and assessment.

Four-year degree

Capacity and capability of the RN workforce needs to keep pace with Australia's rapidly increasing and changing health care demands. ACN believes it is timely for the profession to consider the potential benefits of a four-year Bachelor of Nursing degree to ensure the RN workforce is suitably prepared to meet Australia's current and future health care needs. The four-year degree may address some challenges associated with pressure to introduce specialisation within the undergraduate program and allow curricula expansion to support the potential of RN prescribing into the future.

General comment on the Discussion Paper

In line with international trends, Australia must look to expand the prescribing privileges of nurses working at advanced practice levels by building on the outcomes of the Department of Health Registered Nurse and Midwife Prescribing Symposium. While the NMBA's undertaking to develop the Discussion Paper for consultation is a positive step forward, ACN notes our concern that the consultation paper is light on detail and does not provide concrete proposals to drive policy development. The Discussion Paper does not sufficiently build on the Symposium dialogue and casts a wide net for feedback providing limited guidance on the potential design and implementation of the various models in the context of Australia's federated health system. The inclusion of more detailed well-evaluated proposals setting out conceptual designs and their relevant regulatory issues and potential risks and opportunities would have benefitted the consultation. Additionally, more developed proposals would have honed the scope for feedback on potential education, competency and governance arrangements for the presented models.

Options for models for prescribing under a nationally consistent framework

Autonomous prescribing

Q1. Should the NMBA and ANZCCNMO explore the expansion of the model of autonomous prescribing for registered nurses beyond nurse practitioners and endorsed midwives?

Yes, the NMBA and ANZCCNMO should judiciously explore the expansion of the model of automatous prescribing for registered nurses beyond NPs and endorsed midwives. ACN supports the principle of expanding autonomous prescribing for advanced practice RN roles as a means of increasing health service access and systems efficiencies and, therefore, the cost effectiveness of care. The autonomous prescribing model has potential to increase service flexibility, to enhance capacity of nurse-led clinics and to reduce some demands on medical services.

While in support of exploring the expansion of the model of autonomous prescribing, the current discussion on autonomous prescribing is limited and does not canvass the many complex issues that accompany the model. For example, how autonomous prescribing models will differ or align with autonomous prescribing for NPs. There may be professional tensions around the scope of practice of NPs and the scope of practice of RN APN prescribing roles. Issues will require significant examination and consultation and ACN suggests incremental changes underpin any concrete proposals in future.

ACN member feedback

Overall, ACN members who provided feedback in relation to this question supported the idea of the NMBA and ANZCCNMO exploring the expansion of the model of autonomous prescribing for RNs beyond NPs and endorsed midwives. There were, however, members who did not offer support on the basis that any introduction of broader prescribing rights for RNs would reduce incentives for nurses to attain NP qualifications. The following lists a range of ACN member responses regarding the advantages of expanding the model of autonomous prescribing, there were only a few comments that reflected on the existing model for NP and endorsed midwife prescribing.

- There was a well-supported view that the model of autonomous prescribing would improve access to and the timelessness of health care in regional and remote areas and in community and residential aged care.
- The model would be beneficial within clinical areas with limited medical coverage such as the correctional health environment.
- Due to increasing service demand pressures on medical professionals across the sector and medical workforce shortages in some areas, as an initial step, it would be beneficial to enable RNs to prescribe Schedule 2 & 3 medications.
- RN autonomous prescribing for experienced nurses would support improved consumer care, especially in private hospitals where medical practitioners are not readily available, particularly after hours.
- The model could improve response times to changing patient symptoms by facilitating more immediate alterations to medications, especially in the case of antibiotics switching from IV to oral administration. This could improve quality use of medicines (QUM) through better patient care and being active in the aims of antimicrobial stewardship. Clinical Nurse Consultants are currently involved in the patient assessment, medication discussions and decisions within the treating team, RN autonomous prescribing would potentially enhance and better utilise their roles.
- Autonomous RN prescribing would have health service benefits such as improved access to primary care and hospital admission avoidance and workforce benefits such as improved job satisfaction, incentives for pursuing higher education, greater recognition of skills, and greater inter-professional respect and collegiality.
- For the profession, the main advantage would be the ability for the practitioner to work to their full scope of practice.

Prescribing under supervision/designated prescriber (however termed)

Q2. Would a model of prescribing under supervision/designated prescribing (however termed) by RNs and midwives provide increased access to health services for consumers?
Yes, ACN believes there is significant potential for this model of prescribing to increase access to health care service. However, given the broad description of the model and the lack of consideration given to the complex regulatory, policy, quality and safety and other matters that accompany the introduction of this model in the context of Australia's federative arrangements, the discussion paper does not provide enough background detail for the questions it proposes.

There is a significant body of preparatory work to be undertaken to inform proposals under the model of prescribing under supervision/designated prescribing (however termed) and any proposals need to be heavily guided by well thought out competency and safety provisions. Detailed comparative analysis and evaluation of international models and the Australian context would help form potential proposals for application in Australia. As noted above, ACN maintains that greater standardisation of nursing undergraduate education and advanced practice nursing roles would support an enabling environment for RN prescribing within this model across the sector.

ACN member feedback
While the ACN membership expressed support for a model of prescribing under supervision/designated prescribing there was emphasis on the risks associated with this model in their feedback. There were concerns expressed around creating an additional level and structure of prescribing adding new service and regulatory arrangements to an already complex regulatory prescribing system. There were views expressed that this model would lead to large numbers of prescribers compounding issues around overprescribing and polypharmacy. This is a key consideration for any education component associated with this model of prescribing. The mapping of international models against Australia's service and regulatory arrangements for comparability, particularly independent prescribers in the UK who work to formulary is essential to demonstrate applicability and potential of proposals in the Australian health care context.

More specific comments by ACN members who responded included:

- The model requires strong provisions in place to support and protect Quality Use of Medicines (QUM).
- The model would be particularly beneficial in improving access to health services in regional and remote areas, in aged care and within hard to reach communities.
- Nurse prescribing under this model would enhance health system capacity to manage chronic conditions, to promote better consumer self-management and care, and would create opportunities to reduce pressure on emergency departments, and GP practices and reduce waiting times.
- The model could reflect current practice with RNs initiating medicines within the designated specialty then seeking medical authorisation.
- The model is preferred to autonomous prescribing as it works to leverage the knowledge and skills of RNs while providing the safeguard of supervision.
- Of primary importance is strategic planning to determine which clinical areas and RN roles should incorporate prescribing rights under the model.
- This model would be particularly advantageous in regional hospitals where medical officers are often on-call and in residential aged care facilities potentially reducing unwarranted hospital transfers.
- To optimise the potential of the model, its design should avoid delay times associated with the 'supervision' process.
- Clarity around the roles and responsibilities of the 'supervisor' is paramount for consumer safety under this model and is dependent on supervisor/designated prescriber competence and commitment to QUM.
- It is essential that any RN eligibility requirements developed under this model do not assume years of RN practice and positions held equate to competence and safe practice.

Q3.

a) What should the prerequisites, competence, regulatory policy and governance be for prescribing under supervision/ designated prescriber for an RN or midwife?

ACN is of the view that due to the broad description of the supervisor/designated prescribing model and lack of detail about its potential application in the Australian context, it is premature in the development of the proposed model to specify requirements for pre-requisite, competence, regulatory, policy and governance arrangements.

ACN urges the NMBA to undertake some initial work to formulate conceptual designs and proposals to provide a more concrete starting point for these deliberations. With ACN's reservations noted, at a minimum, ACN would expect the model to be underpinned by prerequisite, competence, and regulatory policy and governance arrangements similar to those already supporting NP practice with some adjustment to reflect relevant scope of practice requirements. The following inclusions should be considered:

- ***Eligibility criteria*** requiring that:
    - Participating RNs work in APN roles as recognised by classified APN titles defined by the NMBA. It is anticipated that this definition will stipulate minimum professional experience and skills and knowledge acquisition.
    - RNs possess required post-graduate qualifications for recognition as a prescribing APN by the NMBA.
    - Completion of a NMBA approved program of study for prescribing medicines within APN RN scope of practice.

- ***Governance/regulation policy*** to include (but not limited to):
    - Application of relevant regulatory policy to ensure safety and quality and compliance with all legislative requirements governing medicines prescribing, supply and administration as in place for NPs and Endorsed Midwives.
    - Establishment of appropriate NMBA practice standards and schedule of medicines registration standards.
    - Endorsement to practice in a specific area and context of practice and within defined scope of practice with a specific clinical management plan (however named).

- Additional CPD requirements to maintain, improve and broaden knowledge, expertise and competence for prescribing and administration of medicines within scope of practice.

- ***Designated prescriber:***
  - National regulation and policy will be required to guide the practice of authorised prescribers under this model. This may include eligibility criteria for participating authorised prescribers and principles and requirements for collaborative practice.

ACN member feedback

The following lists a range of ACN member recommendations for what the prerequisites, competence, regulatory policy and governance should include for prescribing under supervision/designated prescriber for an RN prescribing (*please note, on some matters there was a wide variation of opinion*):

Prerequisites:

- A designated university-based prescribing course including medication management, drug calculations, pharmacology and pharmacokinetics, prescription documentation and assessment and evaluation.
- Completion of relevant pharmacology and pathophysiology and diagnostic units at a Masters level.
- Completion of a post-graduate qualification in the speciality area coupled with a period of guided practice by the designated prescriber.
- At a minimum, RNs hold a graduate diploma in Advance Nursing Practice (whatever speciality) and a minimum of 3-5 years clinical experience.

Competency:

- Demonstration of competency in the overarching concepts of pharmacokinetics, correct prescription documentation and appropriate patient assessment techniques and evaluation.
- Demonstrated competence in pharmacodynamics, pharmacokinetic and pharmacogenomics, diagnostic/assessment skills to form differential diagnosis, formulating management plans which, may or may not include prescribing drugs, and to evaluate treatment outcomes.
- Competency per health services discretion.
- A set of competences for various settings and nurse experience and education will be required. A one-size fits all approach would be either too simple for many or too complex depending on how it is arranged.

Governance/regulation/policy:

- Initially limit prescribing to commonly scheduled drugs and for repeat prescriptions only, with a medical practitioner required to issue first prescription. Prescriptions for S8s should be referred to medical practitioners.
- Protocols will be required for prescribing within scope of practice and for medications to be prescribed. This includes, but is not limited to a nominated medical provider within a health care team and practice supervisory structure including nurse management and health service structure.
- NMBA titles will need to be established for the endorsement of RN prescribers.
- The establishment of medications safety committees within health services and audit systems to determine whether there is appropriate supervision, designation and prescribing.
- The inclusion of pharmacy review of medication and prescribing practices at appropriate stages should be considered.
- Consideration be given to limiting prescribing by regulation to a set of scheduled drugs with restricted drugs requiring referral to a medical practitioner. The set of scheduled drugs could be reviewed for potential expansion after an initial introductory period.
- The availability of professional indemnity insurance (PII) may be a consideration if the model is applied within private practice.

General comments:

- RNs prescribing to standing orders or clinical practice guidelines works well in regional and remote settings. This model could be applied with modification.
- The RN prescriber model should be underpinned by a manual/guide such as the QLD Primary Clinical Care Module that already allows endorsed RNs to supply medications based on their professional assessments.
- Governance arrangements should include local executive nursing and midwifery medications expert advisory committees that include medical and pharmacy representatives to monitor and support safe prescribing arrangements.
- Nationally recognised and consistent credentialing for supervisors should be required to guide quality use of medicine, effective multidisciplinary models of care and effective mentorship.
- Policy should support a career pathway for existing endorsed RIPRN to prescribe under the proposed designated prescriber model.
- Governance arrangements must be established at federal level to avoid variances between jurisdictions, including standardise mandatory education requirements.

b) Should there be prerequisites for prescribing under supervision/ designated prescriber and if so what should they be?

Yes. As noted above (including within ACN member responses), ACN is of the view that minimum prerequisites for the RN prescribing under supervision/designated prescriber model should include post-graduate education qualifications and the completion of a dedicated prescribing course. Additionally, consideration should be given to eligibly requirements for the designated prescriber. This may include principles and requirements for collaborative practice. What form prerequisites take will be depended on substantive proposals around this model of prescribing.

c) Should the NPS Competencies limited to relevant elements be the basis of the competence framework? If not what other approach is suggested?

The NPS competencies may provide a sound starting point for the development of competencies for the prescribing framework, however, a detailed discussion on the merits of their potential applications in the context of RN prescribing would be beneficial.

ACN member feedback

There was some support among ACN members for using the NPS Competencies as the basis of the competence framework. More specific comments by ACN members who responded included:

- The NPS Competencies are appropriate providing CPD requirements mandate annual competency demonstration.
- The NPS competency framework is comprehensive and in the spirit of national registration sets expectations for all prescribers. This may support inter-professional acceptance of RN prescribing.

d) What should the regulatory policy be?

See response to Q3(a).

e) ***What would the governance arrangements be to ensure quality use of medicines****?*

ACN agrees with the principles outlined in the Discussion Paper to support expanded registered nurse/midwife prescribing models and agrees that any prescribing framework must comprehensively reflect the role of the prescriber in the Quality Use of Medicines as one of the central objectives of Australia's National Medicines Policy. QUM will be best supported by a comprehensive prescribing framework that articulates QUM practice and establishes appropriate NMBA endorsed RN prescribing standards including the considerations outlined under *Q3.(a).*

Prescribing via a structured prescribing arrangement

General comment

It is noted that the following statements within the Discussion Paper are contradictory and that there is a need for clarification as the second sentence assumes the NMBA and ANZCCNMO need to work together to address a deficit in undergraduate preparation:

> P.8 "*It is the current view that the preparation of undergraduates in Bachelor of Nursing and Bachelor of Midwifery programs provides the underpinning education to support RNs and midwives to safely administer medications via protocol or standing orders (a structured prescribing arrangement) as a part of normal scope of practice*".
> P.8 "*The NMBA and ANZCCNMO will work with the Australian and Midwifery Accreditation Council to ensure the preparation of both midwife and RN undergraduates to safely administer medications via protocol or standing orders as a part of normal scope of practice in included in all relevant programs.*

As this work progresses, ACN notes the importance of providing adequate discussion background and detail to allow stakeholders to provide informed and well-considered feedback to the NMBA and ANZCCNMO.

Q4. ***Will a framework encompassing three forms of prescribing meet all public and private health service requirements?***

Given the current proposals for the prescribing models lack of detail, it is difficult to conclusively determine whether a framework incorporating three forms of prescribing will meet all public and private health service requirements. Theoretically, the models provide a set of prescribing options that health services could look to employ depending, for example, on their particular population health needs, health workforce capability, capacity and resources and service type and reach. However, at this stage, it is unclear how the models would be structured and applied within the context of national registration and accreditation and how they would efficiently, effectively and safely facilitate RN prescribing. Should a framework be established with the three models described, a staged introduction of the models may ensure their full introduction over time. The national implementation of RN prescribing via a structured prescribing arrangement may be a more immediately achievable and practical first step.

ACN member feedback

Among ACN members who responded, approximately two thirds agreed that a framework encompassing three forms of prescribing would meet all public and private health service requirements, while approximately a third were unconvinced. Comments included:

Yes.

- This would be the ultimate model for all Australian RNs, if based on the RIPRN model of nursing underpinned by the comprehensive training to a graduate certificate in advanced practice nursing.
- The impact of the framework will be dependent on the breadth of service adoption and on the suitability of the model applied.
- Yes, however, with some reservations as it is unlikely that it will meet ALL public and private health service requirements. The framework would certainly improve access and timeliness of health care for consumers.
- The flexibility under this type of framework should enable all areas of care provision to be met *if* supported and enabled by health service providers.

No.

- The question posed is far too broad and, while responding "no", the framework would generally meet needs. There will always be exceptions to access to services regardless of the adopted model.
- There is need for much greater stakeholder discussion in relation to the framework to assess viability in the Australian context as well as ongoing evaluation and development of any model/s post implementation.
- It is difficult to gauge at this stage of the discussion.

Q5. ***Are there areas of patient and/or service need that will not be met by developing this framework for RN and midwife prescribing?***

Once again, ACN is of the view that due to the broad nature of the proposals within the Discussion Paper it is difficult to form a definitive response to this question. Assuming the framework is progressed with the three proposed models, the implementation and impact of any of the models will be largely dependent on adoption by service providers as well as inter-professional good will and collaboration. It will be difficult to predict areas that will be serviced by the proposed framework, as there are variables that fall outside the influence of regulation. Supervisory arrangement or workforce resources within particular health settings may restrict the rollout and limit the viability of RN prescribing in those areas.

ACN member feedback

Among ACN members who responded just under half assumed there are areas of patient need that will not be met by developing a framework for RN prescribing. Comments included:

- General practices and public hospital services may not embrace RNs prescribing as services in metropolitan areas are well covered by medical practitioners.
- Meeting service needs through adding more prescribers cannot be assumed as areas of need may be non-medicinal. Expanding prescribing rights may have unintended consequences such an increasing the burden on health budgets. Additionally, expanding prescribing poses down-stream risks such as services cuts due to increasing health budgets.
- It is likely that the introduction of these significant changes would be staged, therefore, initially there will be areas of unmet need.
- Smaller health and aged care facilities may not have adequate supervision to support the safe implementation of the models.

Proposed framework for RN prescribing

Q6. ***Does this table accurately reflect the possible future direction of RN prescribing?***

The high-level detail in this table is an accurate reflection of the possible future direction of RN prescribing as outlined in the Discussion Paper except for the nurse practitioner-autonomous prescriber column. The brief discussion on page 7 under *Options for models for prescribing under a nationally consistent framework - Autonomous prescribing* raises the future possibility of expanding the existing NP model for RNs *beyond* NPs while Table 1 refers to Nurse practitioner-Autonomous prescriber and outlines existing prescribing framework. The intent of the table and its proposals is therefore unclear.

ACN member feedback

Among ACN members who responded, the large majority agreed that the table is an accurate reflection. Specific comments for consideration included:

- Noted concern is that under Prescribing via a structured prescribing arrangement the statement "*Included as a part of the undergraduate registered nurse curriculum*" is not currently being met. Service routinely require graduate RNs to complete a medication management module before administering medications as their skills are insufficient on entry to nursing to enable them to do this safely. Completion of an undergraduate nursing degree does not necessarily mean an RN will be safe and competent to administer medication under a structured prescribing model.

Proposed framework for midwife prescribing

Q7. ***Should the framework described in Table 2 apply to midwives?***
If not what alternative approach is suggested?

Noting the distinctively different scope of practice of midwives, ACN agrees the models could be applied to midwives and that midwifery should have a separate but, where appropriate, consistent framework. Evaluation of the existing endorsed midwife services arrangements would no doubt be key to determining future prescribing practices for midwives.