

# SUBMISSION

Monday, 7 August 2023

## **AMA Submission to consultation regulation impact statement:**

### **Nursing and midwifery board Registration standard: Endorsement for scheduled medicines — designated registered nurse prescribers**

**July 2023**

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The AMA welcomes the opportunity to respond to the Consultation regulation impact statement (CRIS) that has been circulated for comment by the Nursing and Midwifery Board of Australia (NMBA) on a proposed registration standard for registered nurse (RN) prescribers.

The AMA notes that, in preparing and presenting the options set out in this CRIS, the NMBA has conducted a methodical process over a number of years, including examining the nature of the problem, the impact of proposed solutions and consulting widely. The consultation process that has been undertaken is in welcome contrast to the approach being taken by some other health professions, where the haste to impose solutions to poorly defined problems of access is placing patient safety at risk. This is undermining nationally agreed principles and processes that are intended to regulate non-medical prescribing and ensure the safety of patients.

The AMA's response to this CRIS is focused on the overriding need to ensure patient safety and is informed by:

- Health Professionals Prescribing Pathway Project Final Report (HPPP) of 2013<sup>1</sup>
- AMA 10 Minimum Standards for Prescribing<sup>2</sup>
- National Prescribing Service Prescribing Competencies Framework<sup>3</sup>

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<sup>1</sup> Health Workforce Australia, *Health Professionals Prescribing Pathway Project Final Report*, November 2013.

<sup>2</sup> <https://www.ama.com.au/position-statement/ama-10-minimum-standards-prescribing> accessed 11 July 2023

<sup>3</sup> <https://www.nps.org.au/prescribing-competencies-framework> accessed 11 July 2023

The AMA places a high value on the professional role of registered nurses in working with medical practitioners and patients. We support models of care that fully utilise registered nurses' training and expertise, within their scope of practice.

In relation to prescribing, the AMA is on the record as saying it is supportive of collaborative models of health care where non-medical health practitioners, including nurses, prescribe from limited formularies within their scope of practice in a medically-led and delegated team environment and there is quality evidence of a demonstrable benefit to patients. The AMA recognises that the adoption of specific medically-led models can improve accessibility to necessary medicines while maintaining safety. However, convenience of access should never be prioritised over patient safety and each model must first demonstrate that there are appropriate safety, training and emergency protocols in place. It is important to ensure that care is not fragmented and the expansion of prescribing rights does not undermine efforts to improve anti-microbial stewardship.

The AMA also notes that proposals for extending prescribing rights to other professions are often touted as being a partial solution to address medical workforce shortages. As we are now seeing with the difficulties being faced by the residential aged care sector, in addition to nurse recruitment challenges in both the private and public hospital sectors in every jurisdiction, the reality is that Australia is also dealing with a significant shortage of nurses, with Health Workforce Australia [predicting a workforce shortfall of more than 100,000 nurses by 2025, and 123,000 by 2030](#). Any proposed changes to professional scopes of practice should be addressed solely on their intrinsic benefits and risks – not as part of misconceived attempts to address medical (or other) workforce shortages.

At a population health level, we also note the ongoing concerns about the alarming spread of anti-microbial resistance. If humanity is not to lose the enormous benefits of life-saving drugs, we need to be increasingly careful stewards of this precious resource. If not carefully done and communicated, extending the range of practitioners able to prescribe medications runs the risk of blunting the public health message that prescribing needs to be carefully targeted and calibrated.

This CRIS presents options for RNs to expand their scope of practice which essentially sets it as a yes/no for RN prescribing. At this point and on the basis of the limited information presented in the CRIS, the AMA is not supportive of RN prescribing. However, this does not mean that we fundamentally oppose it. The AMA would be prepared to consider specific models of RN prescribing of Schedule 2,3 and 4 medications (Option 2(a) in the CRIS) where this takes place in medically-led and delegated team environment, where the prescribing is within the scope of practice and in accordance with an *active prescribing agreement* as set out in the CRIS. What is missing from these options is the greater detail required for the specific models.

The examples on pages 21 and 22 provide for positive environments where RN prescribing may be appropriate. What is missing from the examples and the options is that the training and endorsement should be specific to the area that they would work in. That is the RN working in the aged care facility would have specific training and experience in aged care and the endorsement for scheduled medicines as a designated RN prescriber would be limited to this specific field. This would represent a more valuable contribution to the health system with resources directed to encouraging RNs to upskill in areas of need.

The AMA would like to see this explored with pilot studies to ensure that these models are safe and effective in the Australian context. Pending the adjustment noted above and pilot studies the AMA would be open to a modified option 2(a), although this support would also be conditional on the matters set out below being satisfactorily addressed. The AMA is **not supportive** of RN prescribing of Schedule 8 medicines (as set out in both Option 2, and Option 2(b) of the CRIS) given the higher risks involved with this category of medicines.

### **“Authorised health practitioner”**

Only medical practitioners are trained to make a complete diagnosis, monitor the ongoing use of medicines and to understand the risks and benefits inherent in prescribing. Only medical practitioners currently meet all of the high standards required by the NPS MedicineWise Prescribing Competency Framework in order to safely prescribe independently.

The authorised health practitioner must be a registered medical practitioner and must be drawn from the specialty field relevant to the RN’s endorsed field of prescribing. For example, an RN endorsed to prescribe in the field of general practice (with an agreed list of prescribable medications) would be supervised by a Specialist General Practitioner. The same would apply for example in rheumatology and all other specialties.

Accordingly, the AMA is **not supportive** of RN prescribing outside a **medically-led and delegated environment** and therefore does not support RN prescribing where the “authorised health practitioner” is a Nurse Practitioner (or other non-medical practitioner).

This is fundamental to the safety of the patients and to ensure that there are appropriate and timely referrals up to the clinical lead who will have a broader range of diagnostic skills, treatment regimes and prescribing rights should issues arise. The safety of the patient must be at the front of these models, and using workforce shortages as a reason to not pursue this is unacceptable.

## **Closely supervised practice**

Should models of limited, specific prescribing by RNs be pursued, the AMA re-confirms its position that the period of clinical mentorship should be a **minimum of 12 months** for any non-medical practitioners and this must be with a medical practitioner. The proposal in the CRIS for a six month period of clinical mentorship is not supported.

## **Post registration experience**

The AMA notes that the NMBA has increased the post registration experience requirement to three year's full-time equivalent (or 5000 hours) within the last six years. This is a more appropriate requirement than the two years that was earlier proposed.

The AMA is supportive of ensuring only experienced RNs are involved in any program. Noting the AMA's recommendation that this expanded role should be limited to specific fields, we expect that the experience would be in a specific field. It would be inappropriate for an RN to spend three years working in an unrelated field with differing illnesses and treatments to seek endorsement to then work and prescribe where they have limited experience.

The AMA also notes that time-based determinations of competence are outdated and unsupported by evidence. Should RN prescribing proceed, the AMA would very strongly encourage the NMBA to consider a more appropriate competency-based assessment mechanism be developed going forward.

## **Models of non-medical health practitioner prescribing**

The AMA would like to take this opportunity to restate its general position in relation to models of non-medical prescribing that can be supported and which, if adopted, will provide assurance of ongoing patient safety as well as timely access to necessary medicines.

The AMA supports collaborative models of health care where non-medical health practitioners work as part of a medically-led team around the patient.

Non-medical prescribing may only occur in specific situations underpinned by the following principles:

- Non-medical prescribing occurs in a medically led and delegated team environment
- Non-medical prescribing occurs in the context of 'role delegation' not 'task substitution'
- There must be formally documented, collaborative arrangements that ensure:

- diagnosis, ongoing monitoring, and evaluation of adverse events by a medical practitioner
- clear lines of accountability and responsibility
- separation of prescribing and dispensing (with limited exceptions as appropriate in rural/remote circumstances).
- Non-medical health practitioners must have core skills and appropriate competencies for safe prescribing attained by completing high quality, accredited education and training courses
- Course curriculum must meet core competencies in determining when not to prescribe and/or when to refer patients to a medical practitioner
- As occurs for medical practitioners, non-medical health practitioners should be closely supervised during their first years of prescribing practice
- Non-medical health practitioner prescribers must bear some risk for their prescribing decisions.

Models of non-medical prescribing supported by the AMA include:

- continuation of therapy initiated by a medical practitioner as the predominant model

Where this is not practicable or possible:

- prescribing by a protocol or limited formulary
- initiating therapy according to protocol or symptoms
- continuing, discontinuing, and maintaining therapy according to a pre-approved protocol.

As detailed above, medical practitioners are currently the only health professionals trained to fully assess a person, initiate further investigations, make a diagnosis, and understand the full range of clinically appropriate treatments for a given condition, including when to prescribe and, importantly, when not to prescribe medicines.

A general practitioner, for example, has undertaken 10-14 years of training. Using their training, a general practitioner holistically assesses, examines, investigates, diagnoses, refers and coordinates multidisciplinary teams for patients.

A consultation between a general practitioner and a patient is not just a simple transaction about prescribing a medicine, it is a process of differential diagnosis where a range of treatments and management pathways are considered in the context of the patient. It also allows for opportunistic discussions with patients about a range of health care needs, including evidence-based prevention and screening services.

## **Evidence and rationale**

In the interests of supporting patient safety and cost-effectiveness for the health care system, the AMA's view is that any expanded scopes of practice by non-medical health practitioners must be underpinned by a process that ensures:

- there are no new safety risks for patients
- the change to scope of practice is rationally related to the practice of the profession and to core qualifications and competencies of their profession
- the change in scope of practice is consistent with the evolution of the healthcare system and the dynamics between health professionals who work in collaborative, medically-led healthcare models
- the training opportunities for other health practitioner groups is not diminished
- the cost to the health care system will be lower than the current service offering, taking account of supervision costs.

In addition, processes for expanding scopes of practice should also ensure that:

- the required competencies are predetermined, and accredited training and education programs are available to deliver those competencies
- there are documented protocols for collaboration with other health practitioners, in particular protocols that minimise fragmentation of patient care.

## **General comment**

In summary, non-medical practitioner prescribing should only take place within collaborative models of health care where non-medical health practitioners work as part of a medically-led team. This consultation has observed the correct protocols and processes which is welcome, however we would like to see more detail given to the specific models on RN prescribing that the NMBA would like to see.

We note that the CRIS mentions on page 17 that not expanding the role of RNs would limit the ability of the Government to meet the commitments of the Stronger Rural Health Strategy. While we do not agree with this statement, it does present a specific situation with funding and a designated population group where a formal pilot could be run to study the safety and efficacy of these models while also positively contributing to an area of workforce maldistribution.

Any extension of prescribing rights should also be cognisant of the wider impact that this measure would have on the Pharmaceutical Benefits Scheme. Providing tens of thousands of new practitioners with prescribing rights would have impacts on the sustainability of the

scheme. The AMA is also concerned about the potential impact that these models may have on indemnity insurance for the authorised practitioner who would be taking on a greater risk. We encourage the NMBA to engage with medical defence organisations to discuss the risks and potential costs to practitioners.

AMA members greatly value the nurses they work with across the health system and many regularly state that they wish their nurses could do more. We agree there is potential for this, but we need to ensure that the expansion of scope is done safely and with the right goals in mind noting, in particular, that this will not be a solution to medical workforce shortages, which need to be comprehensively addressed as an issue in their own right.