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Nursing and Midwifery Board of Australia Consultation – September 2018

Personal Submission – Proposed Registration standard: Endorsement for scheduled medicines for registered nurses prescribing in partnership

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Thank you for the opportunity to respond to the Nursing and Midwifery Board's proposal to introduce a pathway for registered nurses to apply for endorsement to prescribe scheduled medicines in partnership with an authorised prescriber.

Although I support the proposal for expanding the scope for registered nurses through endorsement to prescribe, I cannot support the current proposal in its entirety. I have concerns about the proposed level of two years' post graduate experience and requirement for only two units of study to be completed to enable registered nurses to apply for endorsement. I also have concerns about the role of partner authorised prescribers, particularly the proposal for nurse practitioners to fill this role, due to the current requirement nurse practitioners to have collaborative arrangements with medical practitioners under the MBS/PBS rules.

Nurse practitioners are authorised to prescribe a range of medications as defined by their scope of practice and formulary (with significant variation between states/territories, settings, roles). There is an urgent need for clinical governance to be standardised across Australia to remove barriers and allow nurse practitioners to work to their full scope of practice in any location without spending many hours wading through red-tape before they can commence clinical practice.

The NMBA consultation paper argues that prescribing by registered nurses will improve access to medicines for communities but has not provided sufficient evidence to support this statement. Since 2010, endorsed nurse practitioners have been able to prescribe medications listed on the Pharmaceutical Benefits Scheme (PBS). The prescribing practices of nurse practitioners were evaluated by Buckley et.al (2013) and highlighted the importance of nurse practitioner's capacity to prescribe a wide variety of medications, particularly in acute, primary and emergency care settings. Current limitations of the PBS restrict the prescribing practices of nurse practitioners, and there is no ability for prescribing under the Repatriation Pharmaceutical Benefits Scheme (RPBS) or for PBS Closing the Gap and S100 medications. These restrictions result in delays in treatment, duplication of services and added cost to consumers, and must be addressed by the Commonwealth government before further layers of complexity are added with the introduction of registered nurse prescribers.

Question 1

Do you agree that suitably qualified and experienced registered nurses should be able to hold an endorsement to prescribe scheduled medicines in partnership with a partner prescriber?

I agree that suitably qualified and experienced registered nurses should be able to prescribe in partnership and I support expanding the scope of practice for registered nurses in Australia. Registered nurses make up the majority of the health workforce and their skills and expertise are under-utilised across a range of health care settings. Increasing the scope of practice for registered nurses has the potential to increase access to health care for consumers; this is particularly

important in vulnerable populations such as residential aged care and in low-socioeconomic, rural and remote regions.

Endorsement to prescribe could provide an avenue for registered nurses to advance their career to become Nurse Practitioners, thus expanding the Nurse Practitioner workforce. A registered nurse with endorsement to prescribe could be employed as a transitional or candidate Nurse Practitioner and prescribe in partnership with experienced nurse practitioners and medical colleagues while completing the Masters Nurse Practitioner degree.

Question 2

After reading the proposed registration standard and guidelines, in your view, are there any additional elements that should be considered by organisations in establishing governance arrangements for prescribing in partnership?

There is a need to standardise governance arrangements for prescribers nationally. Currently each State or Territory has different legislation and requirements for nurse practitioners to practice. This causes confusion and creates barriers and should be standardised to improve workforce capacity and mobility.

There needs to be clarification regarding legal liability for registered nurses and prescribing partners. Professional indemnity policies will need to be reviewed to ensure there is protection for the registered nurse with endorsement for scheduled medicines, partner authorised prescribers and employers.

Current MBS/PBS restrictions require a nurse practitioner or eligible midwife to be in a collaborative arrangement with a medical practitioner. There is a potential for consumers to be burdened with financial cost when provided by a prescription issued by a Registered Nurse in partnership with a nurse practitioner unless changes are made to the PBS and RPBS.

Question 3

Two years' full time equivalent post initial registration experience has been proposed as a requirement for applying for endorsement. Do you think this is sufficient level of experience?

Two years' full time equivalent post initial registration experience is insufficient for applying for endorsement to prescribe. I believe there should be a minimum of three years' full time equivalent experience, which aligns with the requirements for entry into post-graduate Masters Degrees at Australian universities and the pathway for nurse practitioner endorsement.

Prescribing is complex and associated with significant risk to consumers. In order to prescribe safely, clinicians must first be expert in their clinical area of practice and be able to apply their theoretical knowledge, clinical skills and experience to the care of their patients. Hill (2010) quotes several authors who provide differing opinions on ranges of experience to be considered an "expert" from two years (Uhrenfeldt & Hall, 2007), five years (Conway, 1998) and undetermined (Daley, 1999). Further, Hill states that there is a relationship between nurse experience and quality outcomes.

Patricia Benner (1984), in her seminal work "*From novice to expert*", identified various stages of clinical competency and provides a theoretical framework for establishing the growth of registered nurses through education, motivation and experience (Marble, 2009). She posits that in the first year after registration many registered nurses complete new graduate rotations through different areas

of nursing. During this time they are novice nurses in each area that they work, and are trying to consolidate their theoretical knowledge, time management and clinical skills. They practice within a set of rules and do not have experience from which to draw conclusions. The first year of a newly registered nurse's practice has been identified as the most difficult time in their career (Martin et.al, 2011).

In the second year after registration, the registered nurse will continues to consolidate knowledge and skills and experience, may reach a level of practice of marginally acceptable performance and can recognise recurring meaningful situational components of past experience. As they move toward being advanced beginners, they still need guidelines and mentorship.

Benner defines the competent nurse as one who has been nursing for one to three years. They lack speed and flexibility but can cope with multiple demands. At this point they may begin to undertake post-graduate study in their area of interest and move towards becoming proficient but are still not expert.

Prescribing medicines has inherent risk and requires clinical expertise. In the absence of any recent research that makes Benner's theory redundant, her 'novice to expert' theory should be applied when setting standards for endorsement to prescribe.

Question 4

The NMBA is proposing that the education for registered nurses should be two units of study that addresses the NPS Prescribing competencies Framework. Do you think this level of additional education would appropriately prepare an RN to prescribe in partnership?

While I believe that there must be additional study requirements, I do not believe that two units of study in isolation will be sufficient to address the NPS Prescribing competencies framework. Core competencies in prescribing require the prescriber to have skills to take/review medical history, symptoms, medications and diagnoses; to make clinical decisions; to communicate the prescribing decision effectively; and to monitor and review therapeutic and adverse impacts of treatment. Currently endorsed prescribers have experience at the advanced practice level and complete units of study related to clinical assessment, diagnostic imaging, pharmacology and medicines assessment and prescribing as part of higher graduate degrees.

The case examples given in the consultation document do not reflect the seven competencies in the NPS Prescribing Framework. In particular, example two of an endorsed RN working in a residential aged care facility (RACF) provides an example of task-oriented nursing rather than using advanced clinical assessment skills and knowledge to provide evidence-based care. Being unable to contact a GP should not be a reason for a registered nurse to prescribe. In this scenario, the GP may have made a conscious decision not to provide ongoing prescriptions for any number of clinical reasons, and a registered nurse writing a prescription when unable to contact the GP may put the consumer at risk. The 2017 AMA Aged Care Survey Report shows that 35.67% of the 608 doctors surveyed reported that they plan to not take on new patients and will reduce the number of visits, or stop completely over the next two years. The proportion of respondents who visit RACFs has also dropped by 13.55% since 2015. With respondents aged 41–60 the largest age group reporting they visit RACFs (46.94%) and contributing to the highest proportion of monthly visits (49.32%), the report also raises concerns about a future shortage of medical practitioners willing to visit these patients. This reduction would have an impact on the availability and accessibility of partner authorised prescribers in residential aged care.

Question 5

a) **Should a period of supervised practice be required for the endorsement?**
b) **If a period of supervised practice was required for the endorsement, would a minimum of three months full time equivalent supervised practice be sufficient?**

I agree with the proposal that Registered Nurses endorsed to prescribe in partnership should initially have a condition on their endorsement to complete a period of supervised practice under the direct or indirect supervision of a partner prescriber; however this raises a number of issues that need to be considered, namely:

1. Availability of on-site access to supervising doctors or prescribing partners;
2. Access to supervising prescribers may become more difficult as numbers of professionals requiring supervision increases;
3. The need to standardise the process for assessing competence of the RN against the NPS MedicineWise prescribing competency framework; and
4. Organisational support and funding for the period of supervised practice.

I have been unable to find any evidence to support the proposal that a minimum time period of three months full time equivalent supervised practice would be sufficient or insufficient. This proposal needs further consideration.

Thank you again for the opportunity to participate in the consultation process. I am happy to be contacted for additional information if required at [redacted]

Yours sincerely

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