Consultation regulation impact statement

Registration standard: Endorsement for scheduled medicines − designated registered nurse prescriber

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Section 1

Introduction

In 2016, the former Australian Health Ministers' Advisory Council's Health Workforce Principal Committee (HWPC) requested that the Nursing and Midwifery Board of Australia (NMBA) work with the Australian and New Zealand Council of Chief Nursing and Midwifery Officers (ANZCCNMO) to explore potential models of prescribing by RNs. Since 2017, the NMBA and ANZCCNMO have undertaken extensive research and consultation with governments, key nursing and medical stakeholders, RNs and consumers about the potential for RNs to contribute to improving health outcomes for the Australian community.

Australian governments are committed to ensuring that all Australians, including those who live in rural, regional, and remote parts of Australia and those in aged care and disadvantaged communities, can access timely, safe and effective healthcare.

The *National Healthcare Agreement (2022)* affirms the agreement of all governments that Australia's health system should provide all Australians with timely access to quality health services based on their needs, not their ability to pay, regardless of where they live in the country. [1]

The Australian Government's *Stronger Rural Health Strategy*, *Strengthening Medicare Taskforce Report* and *The Future Focused Primary Healthcare 10 Year Plan* are examples of strategies that identify areas where RNs have the potential to contribute to improving access to healthcare and improving the health outcomes of health consumers by broadening their scope of practice. [2,3,4]

As part of the strategy, strengthening the role of the nursing workforce is critical to delivering increasing multidisciplinary team and nursing-based models of primary healthcare across rural and remote communities and other areas where nurses can improve access to care, improve case management and care coordination, reduce the need for hospitalisations and emergency department use and improve patient care results.

Investing in advanced models of care for the nursing workforce not only contributes to healthcare system effectiveness in recruiting and retaining nurses across various health contexts, it will also assist in delivering the key strategies through improved collaborative practices that extend beyond the traditional boundaries to maximise equity across healthcare and respond to growing demands in health and population needs.

The roles and opportunities for all health professionals to grow and change are continually expanding. There is considerable scope for innovative approaches to improve healthcare delivery that make better use of nursing skills and knowledge. The COVID-19 pandemic has had wide ranging impacts on the health of the Australian community. Lockdowns have led to an increase in the number of people who have had their health issues either not managed or access to treatment delayed. The ongoing impacts of long COVID-19 is likely to see an increase in people seeking healthcare and has the potential to create longer delays in people being able to access health practitioners when they need to do so.

The COVID-19 pandemic demonstrated the importance of the nursing workforce in adapting to the unexpected and unprecedented surges in demand for care that ensures continuity and safe care for all. It also highlighted the importance and critical need for innovative roles such as nurse led models of care within the multidisciplinary and primary healthcare team to be able to deliver sustainable successful health system responses for the future that are prepared and resilient against public healthcare emergencies.

Investment in the development of advanced roles for nurses would contribute to this response in terms of the ongoing population health issues that have been created as a by-product of the COVID-19 pandemic. These include people living with chronic conditions who have suffered a disruption in care routines and those who have not accessed care throughout the pandemic, however, are highly vulnerable to complications.

The World Health Organisation *State of the World's Nursing 2020* report recognised that nurses are critical to achieving universal health coverage. The United Nations predicts that there will 1.6 billion people over the age of 65 years by 2050. Associated with the increase in life expectancy is the increase in the burden of disease and chronic complex comorbidities that place even the most comprehensive health systems under strain. [5]

As RNs are integral in the delivery of all facets of healthcare, expanding the scope of practice of RNs provides opportunity to develop innovative models of prescribing that deliver safe, timely and effective access to medicines to all consumers. Expanding the scope of practice of RNs to enable them to prescribe scheduled medicines has the potential to significantly contribute to the ability to effectively respond to the growing demands in health and population needs.

There are a range of areas where RNs can expand and broaden their scope of practice to aid in addressing these issues, the most significant being for RNs to be able to prescribe scheduled medicines. In Australia, RNs are currently able to administer, supply, and adjust medicines. Enabling RNs to be able to safely prescribe medicines in a supervised prescribing model has the potential to assist with improving access to healthcare. Additionally, the International Council of Nurses *Recover to Rebuild: Investing in the Nursing Workforce for Health System Effectiveness Report 2023* found advanced models of care for RNs including the ability to prescribe, could assist in rebuilding the nursing workforce through advanced practice that provides increased career opportunities and assists in recruitment and retention across various healthcare contexts. [6]

In order to align with and deliver these key strategies of the Australian Government, the NMBA ANZCCNMO have developed options for prescribing models for RNs. Implementing models for designated registered nurse prescribing for appropriately trained and supported nurses to prescribe within their scope of practice across healthcare settings is likely to reduce the pressure on Australia's healthcare system and increase timely access to care and medications. These innovative models of care can also meet the needs of Australians living in rural and remote areas, disadvantaged Australians and those who do not access mainstream services. These models also have the potential to alleviate the pressure on access to general practitioner appointments, particularly in areas experiencing workforce shortages. Models of RN prescribing, particularly across the acute and primary care setting, is likely to facilitate flexible service delivery to meet healthcare consumer needs.

A consultation regulation impact statement (C-RIS) is one phase of the overall consultation by the NMBA on the development of a prescribing model for RNs.

This paper seeks the views of stakeholders on the proposed expansion of the scope of practice of RNs to enable them to safely prescribe scheduled medicines through the development of the proposed *Registration standard: Endorsement for scheduled medicines − designated registered nurse prescriber* (proposed registration standard). It describes the objectives, options and impact analysis (risks, costs and benefits) of the proposed standard, to better inform the regulatory, social and health impacts of changes to the supervised prescribing of medicines by RNs.

The C-RIS is informed by extensive consultation already undertaken with both health professions and the public (Appendix C). It has been developed in consultation with the Office of Impact Analysis (OIA), Australian Government, Department of the Prime Minister and Cabinet. The C-RIS will be followed by further public consultation with stakeholders. Feedback provided from the public consultation will assist in the development and preparation of the final decision regulation impact statement (D-RIS).

It should be noted that nurse practitioner (NP) prescribing is out of scope for this C-RIS, as NPs already have authority to autonomously prescribe within their scope of practice.

Section 2

Background

Exploring the roles of the registered nurse in the healthcare system and an examination of national and international literature around RN prescribing provides an important illustration of the need for this approach to reform.

The role of registered nurses in primary care

Primary healthcare in Australia is often the first point of contact for people within the healthcare system, with the rate of primary healthcare services claimed increasing over recent years. Across the country there were 7.6 general practice (GP) attendances per person in 2020-2021 compared to the 6.3 per person in 2018-2019. [7]

Primary healthcare includes a range of health services that includes but is not limited to GP, dental services, and pharmaceutical services. Primary care is provided by a variety of health practitioners other than GPs and include RNs, midwives, Aboriginal and Torres Strait Islander health practitioners, pharmacists, dentists, and allied health practitioners. Primary care may be delivered in a range of settings, including aged care, disability care and the community.

- Demand for primary healthcare services apart from GPs is rising across Australia. Nationally in 2021 there were: 4.3 million Medicare-subsidised services provided by nurses, midwives and Aboriginal health workers compared to 2.8 million general practice nurse attendances in 2018–19. [7]
- There were 750,000 nurse practitioner attendances in 2020-2021 up from around 660,000 services in 2019–20. This represents 2.9 services per 100 people in 2020–21, up from 2.6 in 2019–20. [7]
- There were 3.4 million Practice Nurse/Aboriginal Health Worker Medicare-subsidised services provided in 2020-2021, an increase from 3.1 million services in 2019-2020. This represents 13 services per 100 people in 2020–21, up from 12 in 2019–20. [7]

Access to primary healthcare contributes to the reduction in the number of avoidable hospital visits and potentially preventable hospitalisations (PPH). PPH are conditions in which hospitalisations could have been prevented through the provision of appropriate preventative health interventions, management, and treatment. Access to primary healthcare can improve health and reduce inequality.[8]

The role of registered nurses in our healthcare system

Of the 833,318 registered health practitioners in Australia, almost half (47%) are RNs (395,773). Of this number 62,591 work outside of metropolitan and regional centres − in rural, remote or very remote communities. [9,10]

RNs are comprehensively educated and have a broad scope of practice. They work as a part of multidisciplinary teams and currently have a role in administering, supplying, and adjusting medicines.

Through their pre-registration education programs RNs enter the workforce with foundational skills and knowledge to provide healthcare competently and safely. Throughout their careers RNs complete further education and training so that they can expand their scope of practice to meet the needs of the community. As such the role of RNs has changed over time and they have taken on roles and/or activities that were once part of the scope of practice of other health professions such as inserting intravenous lines and suturing.

As RNs are integral to the delivery of all facets of healthcare, expanding the scope of practice of RNs provides an opportunity to develop innovative models of prescribing that deliver safe, timely and effective access to medicines for all healthcare consumers.

Current prescribing landscape in Australia

Prescribing of medicines in Australia is primarily done by medical practitioners (general practitioners and specialists). Dentists, optometrists, podiatrists, nurse practitioners, and midwives can also prescribe medicines within their scope of practice.

The prescribing of medicines is regulated through the relevant drugs and poisons legislation in each state or territory. That legislation specifies which health practitioners are authorised to administer, obtain, possess, prescribe, sell, supply, or use scheduled medicines.

The Commonwealth also regulates and monitors the appropriate prescribing practice of Pharmaceutical Benefits Scheme (PBS) medicines by all relevant health professions through the Professional Services Review (PSR). The PSR includes mechanisms to protect patients and the community from risks associated with inappropriate prescribing practice though its regulation and response.

Scheduled medicines

Scheduling is a national classification system that controls how medicines and poisons are made available to the public. Medicines and poisons are classified into 'schedules' according to the level of regulatory control over the availability of the medicine or poison required to protect public health and safety. [10,11]

Some medicines have a higher risk of causing harm than others. Also, some medicines are at higher risk of misuse, such as medicines that can cause dependence or addiction. Scheduling is a way of sorting out which medicines or poisons need to be more tightly controlled, and which don't. There are ten schedules that are arranged from least tightly controlled to most tightly controlled.

Medicines are usually in schedules 2, 3, 4 or 8 and are described in the table below. [10,11]

Schedule	Description	Examples
Schedule 2	**Pharmacy medicine** − Medicines that are available on the shelf at supermarkets and pharmacies.	Panadol Ibuprofen Cold and flu preparations
Schedule 3	**Pharmacist only medicine** − Medicines that are available from a pharmacist without a prescription. These medicines are usually behind the pharmacy counter.	Limited topical antibiotics Limited oral antifungals Acid reflux medicines Sleep aid medicines Emergency contraception
Schedule 4	**Prescription only medicine** − Medicines which must be prescribed by an authorised healthcare professional (such as your doctor or nurse practitioner). They may be supplied in hospital or bought from a pharmacy with a prescription.	Antibiotics Anti hypertensives Anticoagulants Cholesterol Medicines
Schedule 8	**Controlled drug** − Medicines or chemicals which have special rules for producing, supplying, distributing, owning and using them. These medicines may only be prescribed by an authorised healthcare professional who may need a special prescribing permit.	Morphine Oxycodone Fentanyl Methadone

The Australian Institute of Health and Welfare's *Health care quality and performance 2022 report*, highlights the following:[12,13]

- During 2021, 317.4 million prescriptions were dispensed under the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS). The government spent $14.1 billion on all PBS and RPBS medicines an increase of 7.0% from 2020 which equates to government spending $541 per person.

- About 87% of all medicines dispensed during 2020-2021 were prescribed by GPs.

- Seven of the 10 most common PBS medicines prescribed were for chronic conditions including hypertension, gastric reflux and diabetes. They were: Rosuvastatin (cholesterol reduction), Atorvastatin (cholesterol reduction), Pantoprazole (gastric reflux), Esomeprazole (gastric reflux), Perindopril (blood pressure), Irbesartan (blood pressure) and Metformin (diabetes).

- Over half of the medicines (54%) were dispensed to people aged 65 and over. People aged 50 and over received 75% of all PBS medicines dispensed.

The Australian system of prescribing medicines has high costs in terms of time, money and human resources. One highly skilled group of health professionals, notably GPs are having to prescribe the bulk of medicines primarily to only one section of the Australian community. This is required largely to manage long term chronic conditions. This is concerning as the *2022 General Practice: Health of the Nation report* raises burnout across the GP profession, unsustainable workloads which are impacting on the provision of patient care and a declining interest in the profession as a career pathway. [14]

Health Professionals Prescribing Pathway (HPPP)

Prescribing has been defined as an iterative process involving the steps of information gathering, clinical decision making, communication and evaluation which results in the initiation, continuation, or cessation of medicines. A prescriber is defined as a health practitioner authorised to undertake prescribing within their scope of their practice.[15]

In 2013, Health Ministers approved the *Health Professionals Prescribing Pathway (HPPP)*. Based on the work of Professor Lisa Nissen and incorporating national and international research, the HPPP was developed to provide a nationally recognised and consistent approach to prescribing by a diverse range of health professionals. This framework details the principles that underpin best-practice prescribing; sets out the steps required for a health professional to prescribe; provides a considered approach to the role of stakeholders and also details various models of prescribing. Three models of prescribing were identified by the HPPP, each based on the level of autonomy afforded to the particular health professional undertaking the prescribing duties. [15]

In 2016, the Australian Health Ministers' Advisory Council developed the *Guidance for National Boards: Applications to the Ministerial Council for approval for endorsements in relation to scheduled medicines* under section 14 of the National Law. This guidance ensures that any proposal put forward for consideration by Ministerial Council is compliant with the *Health Professionals Prescribing Pathway (HPPP)* and reflects consistency across the profession, in the setting of curriculum and qualification requirements for clinical practice standards and guidelines that support the quality use of scheduled medicines.

The *Health Professionals Prescribing Pathway (HPPP) Project* establishes the models of prescribing for health practitioners in Australia and the NMBA has developed the options in this paper in relation to the HPPP.[15]

The HPPP models of prescribing are as follows:

Model 1: Autonomous prescribing

Occurs where a prescriber undertakes prescribing within their scope of practice without the approval or supervision of another health professional. The prescriber has been educated and authorised to autonomously prescribe in a specific area of clinical practice. Although the prescriber may prescribe autonomously, they recognise the role of all members of the healthcare team and ensure appropriate communication occurs between team members and the person taking medicine.

Model 2: Prescribing under supervision

Occurs where a prescriber undertakes prescribing within their scope of practice under the supervision of another authorised health professional. The supervised prescriber has been educated to prescribe and has limited authorisation to prescribe medicines that is determined by legislation. The requirements of the National Board, policies of the jurisdiction, governance frameworks and policies and procedures of the employer or health service. The prescriber and supervisor recognise their role in the healthcare team and ensure appropriate communication occurs between team members and the health consumer receiving the prescribed medication Supervision guidelines are established for prescribing under supervision and should be tailored to the prescribing agreements and clinical governance frameworks, policies and procedures developed by the employer or organisation, taking into account the RN's experience and context of practice and can be guided by the NMBA's *Supervised practice framework*.

Model 3: Prescribing via a structured prescribing arrangement

Occurs where a prescriber with a limited authorisation to prescribe medicines in accordance with legislation, requirements of the National Board and/or jurisdictional or health service policy supplies and administers under a guideline, protocol or standing order. A structured prescribing arrangement should be documented sufficiently to describe the responsibilities of the prescriber(s) involved and the communication that occurs between team members and the person taking medicine.

Models of RN prescribing in Australia

Nurse practitioners (NPs) endorsed by the NMBA are able to prescribe medicines under HPPP Model 1 – autonomous prescribing. As at December 2022, there were 2,494 NPs or 0.7% of the overall RN workforce. [16]

Previously, RNs with an endorsement for scheduled medicines in rural and isolated practice were able to prescribe under HPPP Model 3 – prescribing via a structured prescribing arrangement. As at 1 February 2023, there were1,275 RNs with an endorsement for scheduled medicines or 0.3% of the overall RN workforce were able to obtain, supply and administer schedule 2, 3, 4 and 8 medicines in rural and isolated practice settings under a structured prescribing arrangement and protocol.[16] This endorsement however has now been retired as of April 2023. This is due to Australian states and territories now being able to regulate the safe use of medicines by rural and isolated practice RNs through local medicines and poisons legislation, policies and protocols and no longer require additional regulation by the NMBA.

International RN prescribing models

Prescribing by nurses is well established internationally. Prescribing by nurses in either autonomous or collaborative prescribing models is legislated in the United States (US), Sweden, South Africa, Israel, China, Cyprus, United Kingdom (UK), Canada, Ireland, New Zealand (NZ), the Netherlands, Madagascar, Ethiopia, Pakistan, and Australia. The following international examples of nurse prescribing models provide valuable guidance to inform the development of designated prescribing by RNs in Australia. Many of these models of prescribing were developed to support health reform objectives, improve safe timely access to medicines for consumers and to improve access to care. The evidence from the evaluation of these models is that registered nurses who are educated to prescribe do so safely and effectively within their scope of practice.

Nurse prescribing was introduced in Sweden in 1994 when aged care and district nurses gained the authority to prescribe over-the-counter medications. In 2000, the right to prescribe was extended to other specialist nurses working in community care or home nursing who have completed education at the post graduate diploma level. [17]

In the UK, various forms of prescribing have been in place since 1994, when a health visitor formulary was introduced. An expanded prescribing formulary was introduced in 2002 facilitating forms of nurse prescribing in other health settings. In 2006, this formulary was superseded by legislation that enabled independent nurse prescribers, who have completed specific prescribing training (also required for dentists, independent prescribing pharmacists and optometrists), to prescribe from the entire British National Formulary (BNF) within their scope of practice. [18]

In Ireland, nurse prescribing was introduced in 2007 with prescribers gaining the regulated title 'Registered nurse prescriber'. RN prescribing is conducted within employment models, in hospital, nursing home, clinic or other health service settings and requires a collaborative practice agreement between a medical

practitioner, the health service and the RN prescriber. An independent review of nurse and midwife prescribing in Ireland in 2009 identified that the model of prescribing was safe and appropriate. [19]

In 2011, NZ legislation enabled diabetes specialist RNs to prescribe 26 medicines related to diabetic patient care. In 2013, further amendments extended prescriptive authority to other health practitioners under either designated or delegated authority. In 2016, regulations for other RN prescribers came into force enabling RNs practising in primary health and specialty teams who meet educational requirements of the Nursing Council of New Zealand (NCNZ) to prescribe under the designated authority criteria.19 RNs practising in primary health and specialty teams now also incorporate RNs prescribing in diabetes health. These RN prescribers predominately work with people with common, chronic, and long-term conditions to provide timely access to care. The model enables appropriately qualified and experienced RNs to prescribe from a limited formulary independently and within their scope of practice for patients under their care. [20]

International reviews of the literature related to RN prescribing

An exploratory literature review in 2018 of prescribing by nurses and midwives identified that RN prescribing has dual benefits for patients as well as the nursing profession. Surveys from RN prescribers reported on the RN advanced scope that effectively facilitated continuity of care through improved access to medications as part of nursing care plans. Additionally, RNs reported that having authority to prescribe, provided opportunities for increased professional recognition and respect, including enhanced career development. RN prescribing also contributed to greater avoidance of hospital admissions, as the RN was able to assess, prescribe, obtain and give medicines quickly and potentially avoiding a hospital admission. [21]

RN prescribing has also been anecdotally reported to promote health service cost effectiveness, especially in public health scenarios. The International Council of Nurses report that in order to invest and rebuild health systems to manage the COVID-19 backlog, COVID-19 waves and non-COVID-19 care, advanced practice roles of RNs could be cost effective in addressing population health, meeting the needs of increasing chronic care requirements whilst also having a positive effect on the nursing workforce in terms of retention and recruitment. [7]

Other studies have reviewed RN prescribing and patient perceptions and suggest that patients appear satisfied with RN prescribing on a range of different aspects, including accessibility, timeliness and convenience. Also reported was the increasing quality of the relationship between RN prescriber and the patient characterised by the RN providing continuity of care, information, and health promotion regarding medication and treatment. Interestingly in these studies, 46% of patients reported that GPs were busy and patients felt minor problems were best dealt by the RN prescriber, leaving the GP free to deal with more serious problems. Out of 15 patients treated by an RN prescriber, 13 participants (86%) felt that their relationship with the RN was enhanced and more valued as a result of the RNs capability to prescribe.[21,22]

RN prescribers are supported and accepted by patients in several studies that reported a high proportion of patients who have experienced RN prescribing having no preference in relation to who they may see regarding future treatment, i.e., either an RN or medical practitioner. These findings suggest that many patients are comfortable with an RN prescribing, although a small minority of patients acknowledged a preference to still receive their prescriptions from medical practitioners in areas where they could also get prescriptions from RNs.[20]

In 2016, a review of *Non-medical prescribing versus medical prescribing for acute and chronic disease management in primary and secondary care* found that pharmacists and nurses with varying levels of undergraduate, postgraduate, and specific on-the-job training related to the disease or condition were able to deliver comparable prescribing outcomes to medical practitioners. Non-medical prescribers frequently had medical support available to facilitate an innovative and collaborative practice model. [23]

Medical practitioners in the UK, where much of the RN prescribing literature is published, have generally reported positive perceptions about the contribution of RN prescribing, identifying that they could foresee the benefit to their patients. However even though the medical practitioner views on the supervision of RN prescribers were positive there were concerns raised about the time required to undertake their prescribing and remuneration of the role. [20,21,22]

In 2010, studies suggested reduced length of hospital stay related to RN prescribing and evaluated the impact of prescribing insulin and oral hypoglycaemic medication by RNs who provide diabetes care. The outcome revealed a reduction in length of stay in the RN prescribing intervention period by an average of three days (14.5 vs 17.5 days).[24] In another study the length of stay was reduced by two days in the RN prescribing intervention group (seven vs nine days). Reduced medication errors were also reported in both of these studies for insulin and hypoglycaemic agents, with reported medication errors lower in the intervention group (4 vs 6) and an overall mean reduction of 21 errors. [24,25]

In another study an evaluation of 32 community patients was undertaken to determine the time taken for patients to receive medication prescribed pre and post implementation of RN prescribing in the palliative care setting. The study demonstrated that, 19% of patients obtained medication between 2-6 hours and 34% between 24-48 hours prior to implementation. Post implementation of RN prescribing resulted in 50% of patients in the palliative care setting receiving medication within 5 hours and 86% in less than 24 hours which was a significant improvement. [26,27]

In a study of RN prescribers, 776 participants reported that they felt confident in their prescribing practice. In this study the participants also identified factors preventing prescribing which included inadequate formulary, lack of prescription pads and objection by some medical staff. The study also identified degrees of limited support from other clinicians, a lack of confidence to negotiate prescribing responsibilities, imposed restrictions on RN prescribers, and a reduced confidence resulting from the time lag between course completion and registration with a professional body.[24]

The ability to prescribe is dependent on the prescriber's education and confidence to do so. Most studies reported that generally RNs felt confident in their prescribing practice and the health consumers who had experienced RN prescribing and the public also felt confident in RN prescribing. Suitably trained RNs are able to diagnose and prescribe within their scope of practice. A more recent evaluation of RN prescribing also reported that RNs' prescribing decisions were clinically appropriate across a range of different dimensions, that nurse prescribers are safe and that there appeared to be little difference across the prescribing practices between GP and RN prescribing in relation to dose and medication to be prescribed. [19,28,29,30]

Although Australia has a federated government model, there is an opportunity to extend the prescribing rights of RNs in a nationally consistent manner, including the approaches to education, competence and practice standards in relation to prescribing. A nationally consistent model of endorsed prescribing by suitably educated and qualified RNs has the potential to reduce the risk of confusion, inconsistency and potentially increase the confidence in the safety and effectiveness of health professional prescribing models, while retaining the current sovereignty of the states and territories to authorise prescribers under their relevant drugs and poisons legislation.

Section 3

Statement of the problem

Addressing inequities in access to timely, safe, and appropriate quality healthcare in Australia has been long standing and continues to create ongoing challenges. The impact of these inequities is particularly evident in rural and remote areas, aged care, and hospital settings and in settings with communities who do not always access mainstream services. Reduced access to quality healthcare contributes to individuals experiencing, in general, poorer health outcomes.

There is considerable scope for innovative approaches to improve healthcare delivery that make better use of the skills and knowledge of Australia's nursing workforce. Allowing appropriately trained and supported nurses to prescribe within their scope of practice across healthcare settings is likely to reduce the pressure on Australia's healthcare system and increase timely access to patient care and medicines. Access to nurse prescribers also has the potential to alleviate the pressure points within healthcare particularly in areas of workforce shortage and can assist in building workforce capacity and sustainability.

An ageing population and an increase in chronic health and comorbidities as well as the impacts of the COVID-19 pandemic have contributed further to issues in the healthcare system. A strategic and innovative approach in the form of complementary reform and in line with current health strategies and initiatives is required to address these inequalities and provide an appropriately skilled and better distributed RN workforce where RNs can work to their scope of practice maximising workforce potential in the form of more flexible care delivery which is crucial to improving health outcomes

The impacts of COVID-19 on the utilisation and access to healthcare services

The COVID-19 pandemic has exacerbated inequities with access to healthcare for consumers being further limited due to lockdowns, and border closures causing workforce shortages in key areas. Wider impacts have been the health impact to the Australian community, the inability of Australians to access care due to the prolonged lockdowns which has led to a backlog in people accessing care for management, diagnosis and treatment of health issues or subsequent diagnosis in treatment and management delay. There are ongoing challenges to the supply and distribution of the health workforce which has resulted in a reduction in the number of medical practitioners working outside of large cities, with some country towns not having access to a general practitioner at all. Where there are medical practitioners in rural areas, it is often reported that they are overworked and that access to health services particularly general practitioners is difficult for consumers. In these circumstances expanding the scope of practice of RNs to enable them to prescribe scheduled medicines has the potential to significantly contribute to the ability to effectively respond to and manage healthcare and healthcare emergencies.

Inequities across healthcare in rural, regional and remote communities

The situation for patients living in regional and remote communities is challenging. As the *Stronger Rural Health Strategy* indicates, Australia continues to face a significant maldistribution of the medical workforce with regional, rural, and remote areas receiving far less access to medical services than the major cities. Patients living in rural communities are having to spend considerable time and effort to access health services. They are driving long distances and waiting to get their basic healthcare needs met. These patients have shown to be more likely to be living with long-term health conditions such as arthritis, asthma, back problems, diabetes, heart and vascular disease which can add further considerable stress on the healthcare system. Due to their location and poorer access to, and use of, primary healthcare services, this population encounter higher rates of injury, hospitalisation and death in comparison to people living in major cities. [2]

Cultural and social inequities in healthcare

Cultural and social backgrounds and geographical location should not be barriers to achieving timely access to healthcare. These barriers could be reduced with innovative models of care and the expansion of RN roles. The number of medical practitioners moving into general practice training programs is declining and over the past year there have been a multitude of media articles about the lack of general practitioners, with people stating that they are waiting several weeks to see their practitioner. Equal access to healthcare is an issue that Australian governments have been working to address over many years. Enabling collaborative models of RN prescribing can maximise access and add additional flexibility to meet identified healthcare needs of the Australian population. [19]

An ageing population and the impacts for healthcare

In addition to these challenges there is an ageing global population. The World Health Organisation (WHO) predicts that by 2050 there will be 1.5 billion people over the age of 65 years of age. Australia's population as of September 2022 was estimated to be 26,124,814 people. 16.2% of this population is already aged at 65 years or over and by 2066 it is predicted that this age group will increase to 23% of the total population and those aged over 85 years will increase to 5%. [3]

This has implications for healthcare as with increasing life expectancy is the increased burden of chronic disease which will place enormous pressure on already stretched health services and workforce. There is also increasing demand for acute care services across the spectrum in both hospital and community settings and it has been reported that even countries with the most comprehensive healthcare systems will experience service gaps which will cause disparities in healthcare outcomes. [32] Internationally, many countries have already adopted these innovative models RN prescribing and policy makers, government and health departments in Australia should consider similar models to effectively address and meet the ongoing challenges. The recently released *Strengthening Medicare Taskforce Report* noted that Australia lags behind other countries in making the most of the skills of the primary care workforce. The report proposed a number of recommendations to improve access and outcomes for consumers in the primary care sectors. [3]

These included:

- develop new funding models that are locally relevant for sustainable rural and remote practice in collaboration with people, providers, and communities. Ensure new funding models do not disadvantage people who live in communities with little or no access to regular GP care, and whose care is led by other healthcare providers
- work with states and territories to review barriers and incentives for all health professionals to work to their full scope of practice
- The taskforce also noted that there is a need to break down barries to interprofessional collaboration and teamwork, build trust between professions and accelerate cultural change to allow healthcare providers to work to their full strength in a coordinated approach that maintains the patient at the centre.

Consultation questions

1. **Do you agree or disagree with the problems that have been identified?**
2. **What effects do you think these problems could have on people accessing healthcare?**
3. **Do you have any information, analysis or data that is relevant to the issues being discussed?**
4. **Are there any other problems that you think should be considered as a part of this Consultation regulation impact statement (C-RIS)? If so, please describe what these are and how these problems should be addressed**

Section 4

Why is government action needed?

As discussed in the introduction, Australian governments are committed to ensuring that all Australians, including those who live in rural, regional and remote parts of Australia and those in aged care and disadvantaged communities, can access timely, safe and effective healthcare. This can potentially be achieved through the proposed designated RN prescribing model which has been developed by the NMBA and ANZCCNMO in response to the request by the former Health Workforce Principal Committee to explore potential models of RN prescribing.

The *National Healthcare Agreement (2022)* affirms the agreement of all governments that Australia's health system should provide all Australians with timely access to quality health services based on their needs, not their ability to pay, regardless of where they live in the country. [1]

Although Australia has a federated model of government there is an opportunity to extend the prescribing rights of RNs in a nationally consistent manner, including the approaches to education, competence and practice standards in relation to prescribing. A nationally consistent model of endorsed prescribing by suitably educated and qualified RNs has the potential to reduce the risk of confusion, inconsistency and potentially increase the confidence in the safety and effectiveness of health professional prescribing models, while retaining the current sovereignty of the states and territories to authorise prescribers under their drugs and poisons legislation.

Health Ministers have governing responsibilities under the National Registration and Accreditation Scheme (the National Scheme) including approving registration standards. They also have individual responsibilities for scheduled medicines law authorisations under the relevant state or territory drugs and poisons legislation. A matrix outlining variations between the drugs and poisons legislation of each state and territory has been developed by the NMBA for communication to the Commonwealth, State and Territory Chief Nursing and Midwifery Officers. While these current laws allow for the options outlined in this C-RIS to be endorsed with Ministerial approval, governments can assist in future by working towards a uniform and coregulatory approach of state and territory drugs and poisons legislation which more clearly outline prescribing and can ensure a more consistent approach across states and territories in the future.

Governments also have an interest in ensuring that their regulatory frameworks achieve their stated objectives, including through the National Scheme which is founded on the National Law that is applied in each state and territory. Governments have indicated that RNs should be able to work to their full capability and scope of practice competently to address the health inequities outlined and to allow access to timely, safe, and appropriate quality healthcare. The NMBA has proposed the *Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber* to address this problem.

In a National Cabinet Statement released on 28 April 2023, Ministers reaffirmed their commitment to strengthening Medicare measures which included supporting the nursing workforce to work at top of scope in order to meet community needs and provide models of care to improve access and quality of care. [33]

Additionally, the recently released interim review report *Independent review of overseas health practitioner regulatory settings* (the Kruk review) has been endorsed by National Cabinet. The interim report recognised and identified actions that governments and regulators needed to take to ensure all Australians can access timely and appropriate healthcare. These included structural changes which are required to meet key policy commitments across health, aged care and disability settings. This includes enhancing the skills of health professionals to work to full scope of practice. A key reform priority is to support changes in models of care in the best interest of the Australian Community in order to meet future health service demands. This is underpinned by the need to allow professionals to work to their full capabilities, enabling innovative approaches to education and training that allows for the continuous development of a flexible, responsive and sustainable health workforce that enhances service delivery and ensures the health workforce is able to meet community needs. [34]

For this to occur it is imperative that standards and processes are current, reflect change and are supported by evidence and best practice standards to meet regulation and key government policy commitments that support changes to models of care. The NMBA in its role as the regulator, has responded to changes in healthcare and the environment and is ensuring that new standards developed are current and vital in reflecting healthcare issues. This however this needs to be a coordinated legislative and regulatory approach with government.

On 2 May 2023, Minister for Health and Aged Care, The Honourable Mark Butler in a speech for the National Press Club discussed the need for nurses to be at the forefront of reform in primary healthcare by having the training and expertise to deliver care that a patient needs. The Minister also touched on a pertinent point that even if our health professionals have the training and expertise and can work to their full scope they may be held back by a complex system in which the government intends to fully review through a commission on of scope of practice, one of which the NMBA is currently seeking to test via this consultation. [35]

There is a case for RN prescribing to assist in addressing the inequities outlined in the problem statement. The NMBA is required to put forward advice and recommendations to Health Ministers. This can be achieved through further wide-ranging public consultation that will provide opportunity to test the strengths and weaknesses of the options outlined or any additional options that have not been considered in this paper.

This is a problem that the free market cannot resolve and intervention from Government is required to enable nurses to work to their full scope of practice. In turn, this is expected to contribute to workforce, workforce sustainability and will increase the satisfaction and add value to the registered nurse role through the regulatory bodies' development of health prescribing pathways and of the *Registration standard: Endorsement for scheduled medicines − designated registered nurse prescriber*. This opportunity may also relieve the pressure points and problems identified in the health system that have been outlined in this consultation that directly contribute to health inequities.

Section 5

The role of the NMBA and the National Law in the options being considered

The NMBA is one of 15 National Boards in the National Registration and Accreditation Scheme (the National Scheme). The National Scheme is governed by the Health Practitioner Regulation National Law as in force in each state and territory (the National Law)

The NMBA's functions include registering RNs, enrolled nurses (ENs), midwives and nursing and midwifery students, developing registration standards, codes and guidelines, and investigating complaints made about RNs, ENs and midwives. Protection of the public is the paramount guiding principle for everything the NMBA does.

The National Law empowers the NMBA to develop and approve registration standards codes and guidelines to provide clear guidance about the NMBA's expectations of the nursing and midwifery professions with regards to appropriate professional conduct and/or practice. All registration standards, codes and guidelines must comply with the National Law and be prepared in accordance with the Australian Health Practitioner Regulation Agency's (Ahpra) Procedures for development of registration standards, codes and guidelines. If a National Board proposes a new standard, code or guideline, the National Law requires that the Board ensure there is wide-ranging consultation on the content of the proposal.

The National Law sets out the objectives and guiding principles of the National Scheme. The main objective of the National Scheme is to protect the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered. Other objectives of the National Scheme are to facilitate workforce mobility across Australia; the provision of high-quality education and training of health practitioners; to facilitate access to services provided by health practitioners in accordance with the public interest; to enable the continuous development of a flexible, responsive and sustainable Australian health workforce; and to enable innovation in the education of, and service delivery by, health practitioners.

Under section 38 of the National Law, a National Board can develop registration standards, for example, about 'the scope of practice of health practitioners registered in the profession'. Registration standards must be approved by the Ministerial Council for the National Scheme (comprising the Health Ministers of each state and territory and the Commonwealth) and set out requirements that must be met to obtain and retain registration in that profession (or for an endorsement on a practitioner's registration).

Under section 94 of the National Law, a National Board may endorse the registration of a registered health practitioner registered by the Board as being qualified to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of scheduled medicines if the practitioner holds an approved qualification relevant to the endorsement and complies with any approved registration standard relevant to the endorsement. In addition, when developing standards, codes and guideline the NMBA needs to work within the parameters of other regulatory frameworks such as the respective state and territory drugs and poisons legislation.

Through an extensive process of consultation with stakeholders, health professions and the public, the NMBA has developed options for potential models of RN prescribing.

What options are being considered?

Four possible non-regulatory and regulatory options are presented to enable RNs to work to an expanded scope of practice with additional education and training:

Option 1 – Retain the status quo prescribing practice

Option 2 – RNs expand their scope of practice to prescribe Schedule 2, 3, 4 and 8 medicines under designation/supervision, in accordance with governance frameworks and prescribing agreements. Option 2 aligns with HPPP Model 2: Prescribing under supervision

Option 2(a) – enable RNs to expand their scope of practice to prescribe only Schedule 2, 3, and 4 medicines under designation/supervision

Option 2(b) – enable RNs to expand their scope of practice to prescribe Schedule 2, 3, 4 and 8 medicines except for RNs working in private practice or as a sole practitioner

Consultation question

5. **Do you agree or disagree with the problems that have been identified? Are there any additional options that have not been identified?**

Option 1: Retain the status quo prescribing practice

This option would mean that there are no changes to the current prescribing arrangements in Australia. This option would not require any additional regulatory action or legislative change.

Impacts to consumers, health practitioners, health services and governments

This option would not facilitate improvements in access to healthcare or health service delivery for people seeking healthcare. The status quo in relation would be to continue with only medical practitioners and nurse practitioners having authority to prescribe scheduled medicines in accordance with the respective state and territory drugs and poisons legislation.

Health costs and benefits

Not exploring expansions to the scope of practice of RNs would significantly impact the ability for the *Stronger Rural Health Strategy* to be effectively delivered. Since 2018, the Australian Government has invested $550 million through its *Stronger Rural Health Strategy* to improve the health of people living in rural, regional and remote Australia. The comprehensive package of 12 complimentary measures includes $8.3 million in strengthening the role of the nurses in primary health and 3,000 additional nurses in rural and remote areas across the country. [2]

Further, this option does not support the agreement of all governments that Australia's health system should provide all Australians with timely access to quality health services based on their needs, not their ability to pay, regardless of where they live in the country.

Consultation questions

6. **What are the costs and benefits costs associated with retaining the status quo as identified by the Board?**
7. **Are there other costs and benefits associated with retaining the status quo that the Board has not identified?**
8. **Do you agree or disagree with the costs and benefits associated with retaining the status quo?**

Option 2: RNs expand their scope of practice to prescribe Schedule 2, 3, 4 and 8 medicines under supervision, in accordance with governance frameworks and prescribing agreements

This option proposes that suitably educated, qualified and authorised RNs could expand their scope of practice to prescribe scheduled medicines. To give effect to this option in accordance with the National Law, the NMBA would bring forward a proposed *Registration standard: Endorsement for scheduled medicines − designated registered nurse prescriber* (new standard) to Health Ministers for approval. RNs with this endorsement would be called designated RN prescribers.

The new standard would be made in alignment with HPPP Model 2 − Prescribing under designation/supervision. It would enable RNs who are appropriately educated and qualified to prescribe with limited authorisation that is determined by legislation, requirements of the National Board, policies of the jurisdiction, employer or health service and is within their scope of practice under the designation/supervision of an authorised health practitioner.

The key focus of the proposed new standard is that it promotes safe, timely and improved access to medicines for communities, and promotes workforce flexibility to meet consumer needs.

This option would enable use of multidisciplinary teams and innovative models of care to address current issues in healthcare related COVID-19 backlogs, illnesses arising from non-attendance/or inability to access care during COVID-19, anticipated healthcare issues related to COVID-19 waves, surge requirements in healthcare, the increase of chronic comorbidities, an ageing population, and can addressing inequities in rural health through improved access to patient care. Additionally, RNs who expand their practice to prescribe under a supervision model are provided with career opportunities which may positively effect retention and allow for flexibility and deployment to areas of high need.[4]

Evidence from international studies shows that RNs who are educated and authorised to prescribe, do so safely and effectively within their scope of practice. [1] Based on this evidence, RNs play a considerable role in the assessment, diagnosis, management and evaluation of care provided for consumers. The ability for appropriately educated and authorised RNs to prescribe a range of medicines has the potential to enhance timely access to health services for consumers with the designated RN prescriber and health practitioner working within a clinical governance framework compliant with Quality Use of Medicines (QUM) to a prescribing agreement established by the organisation or employer, and not detracting from other health practitioners who are authorised to prescribe, including medical practitioners.

In addition to the new standard, proposed *Guidelines: For registered nurses applying for and with the endorsement for scheduled medicines − designated registered nurse prescriber* (proposed guidelines) set clear requirements for the establishment of this proposed model of prescribing. The guidelines set out elements that support safe and effective prescribing practices, including the requirement for a prescribing agreement between the authorised health practitioner and the designated RN prescriber, that detail the scope of prescribing practice and clearly establish the responsibility and accountability of the designated RN prescriber and the authorised health practitioner.

Key elements of proposed guidelines are:

- the designated RN prescriber and authorised health practitioner work together in partnership in the provision of healthcare under the designated RN prescriber partnership agreement and clinical governance frameworks established by the organisation or employer.
- the designated RN prescriber is educated to make diagnostic and treatment decisions within their level of competence and scope of practice according to the proposed registration standards – endorsement for schedule medicines – designated registered nurse prescriber and the agreed clinical governance framework in place to support the model of prescribing.
- the designated RN prescriber will be responsible for seeking guidance and/or referring people when their care is outside their agreed governance framework or scope of practice.
- the designated RN prescriber is responsible and accountable for the prescribing decisions they make and are expected to understand, apply, and comply with these guidelines and the requirements of the registration standard, prescribing agreement and clinical governance framework and policies and procedures of the organisation or employer.
- the authorised health practitioner is responsible for working with the designated RN prescriber in accordance with the clinical governance framework and must be aware of the designated RN prescriber's scope of practice with regards to prescribing under supervision. Organisations and employers may be guided by the NMBA's *Supervised practice framework* when determining supervision in prescribing agreements. The framework set out the principles that are central to safe and effective supervision.
- the authorised health practitioner is expected to collaborate with the designated RN prescriber when the people in their care are outside the designated RN prescriber's scope of practice.

What is designated nurse prescribing?

Designated nurse prescribing would occur when an RN with an endorsement for scheduled medicines undertakes prescribing within their level of competence and scope of practice under the designation/supervision of another authorised health practitioner and within the context of a **governance framework**. Designated RN prescribers must have additional formal education and a period of supervision, to develop clinical decision making and critical thinking skills when making prescribing decisions.

Under this option, all RNs can seek to become endorsed as a designated RN prescriber. Whilst the NMBA expects that not all RNs will undertake the necessary education to enable them to apply for the endorsement as a designated RN prescriber, research recently undertaken in 2022 in Australia reported that most Australian nurses demonstrated the preparedness to embrace the role of prescribing under supervision. [31,36]

The designated RN prescriber would:

- have the authorisation to prescribe scheduled medicines under the designation/supervision of an authorised registered health practitioner (a medical practitioner or nurse practitioner) in accordance with relevant state and territory drugs and poisons legislation
- be required to meet the requirements of the designated registered nurse prescriber endorsement, as set out by the NMBA's proposed registration standard (at Appendix A) with supporting guidance outlined in the proposed guidelines (at Appendix B).
- be responsible and accountable for prescribing within their scope of practice within the clinical governance framework and prescribing agreement set out by the organisation or employer
- be required to meet any relevant prescribing policies of the jurisdiction, employer and/or health service

How would the model work?

The designated RN prescriber would be required to work in accordance with a **governance framework**, which includes the requirement for a **prescribing agreement** with an authorised health practitioner.

Governance framework

The governance framework establishes the requirements of the designated RN prescriber, the authorised health practitioner and the employer to enable safe and effective RN prescribing across organisations. The elements of the governance framework to be developed by organisations and employers and tailored to the context of care would include:

- a multidisciplinary medicines advisory committee to provide expert advice and guidance on designated prescribing policies, guidelines, and procedures
- establishment, approval, and review of medications the endorsed RN is authorised to prescribe, including specific details of the inclusion of schedule 8 medicines.
- development of the prescribing agreement, which must include details of the initial 3-month clinical mentorship
- organisational policies related to designated prescribing
- risk management systems and processes for adverse event reporting, incident reporting, reporting of near misses and medication errors
- processes for monitoring, review, and audit of prescribing practices, and
- processes for communicating the prescribing agreement with other health practitioners and consumers.

Prescribing agreement

The prescribing agreement is a key document for the designated prescribing model. It is a written agreement between the designated RN prescriber and the authorised health practitioner and approved by the health organisation/service or employer. This should be retained by the health organisation/service, reviewed regularly, and be subject to audit by the NMBA. Details of the prescribing arrangement must clearly document the role of both the designated RN prescriber and the authorised health practitioner. The prescribing authority may vary according to the health organisation/venue, prescribing agreement and the specific clinical context of its application and must include:

- roles and responsibilities of both the designated RN prescriber and authorised health practitioner
- clients and/or conditions within the scope of prescribing practice of the designated RN prescriber
- medical conditions for which the designated RN prescriber has authority to prescribe
- medicines that the designated RN prescriber is authorised to prescribe; where schedule 8 medicines are included specific details must be outlined including a risk analysis
- responsibility for aspects of care regarding diagnosis and associated prescribing
- clearly documented processes for consultation and referral including provisions where proximity and/or availability of the authorised health practitioner to the designated RN prescriber may need consideration
- arrangements where the agreement is with multiple authorised health practitioners
- a plan for regular review (at least annually)
- a process for monitoring and audit of designated RN prescribing
- processes for resolving or escalating of differences of opinions

Requirements for registration standard for endorsement

RNs must be able to demonstrate that they meet the following requirements of the registration standard for application for endorsement.

1. Current general registration as an RN in Australia with no conditions or undertakings relevant to this endorsement.
2. The equivalent of three years' full-time post initial registration clinical experience (5,000 hours) within the past six years, from the date when the complete application seeking endorsement as a designated RN prescriber is received by the NMBA.
3. Successful completion of:
    a) NMBA-approved units of study leading to endorsement for scheduled medicines as a designated RN prescriber, or
    b) units of study that are equivalent to the NMBA-approved units of study leading to endorsement for scheduled medicines as a designated RN prescriber.

The evidence that you will need to provide when applying for the endorsement for scheduled medicines as a designated RN prescriber is provided at Appendix D.

Examples of where a designated prescribing model may occur

The examples below describe scenario where a designated prescribing model may occur:

Example 1

A designated RN prescriber works in a health service as a part of a multidisciplinary team providing care to persons with a specified long-term health condition, such as diabetes. The RN monitors a patient in the outpatient clinic on a monthly basis and undertakes prescribing relating directly to their long-term health condition. On a routine patient visit, the RN conducts an assessment to determine whether the patient's long-term health condition is stable, and adjusts the medications, in accordance with the health service's governance framework to ensure the maximum benefits. The RN regularly discusses the patient's health status with the authorised health practitioner and escalates care when any changes are identified in the patient's health status. The authorised health practitioner now sees the patient in collaboration with the RN every two months, instead of monthly. This allows the authorised health practitioner to focus on more complex cases, as well as helping to increase clinic efficiency by decreasing patient waiting times to be seen and assessed.

Example 2

A designated RN prescriber working in an aged care facility notes that a long-term resident with severe osteoarthritis requires repeat prescriptions to treat their severe, chronic pain. Unfortunately, the resident's GP cannot be contacted and a long weekend is quickly approaching. After assessing the resident and ensuring the resident's pain continues to be well-controlled, the RN writes the necessary ongoing prescriptions in accordance with the aged care facility's governance framework. The resident is able to receive uninterrupted and appropriate pain control until the GP's next scheduled visit, immediately after the long weekend. The RN notifies the GP of the repeat prescriptions and on the GPs next visit discusses the ongoing management of the resident's pain.

Example 3

A designated RN prescriber is working in a clinic for the homeless during the flu vaccination season. The RN visits the clinic once a week for a half-day session, and several regular clients have presented today requesting a flu shot. The RN (who is also authorised to immunise) prescribes and administers the flu vaccines. During one of the flu vaccinations, one of the longstanding clients mentions that he has had genitourinary symptoms consistent with a sexually transmitted infection (STI). The RN conducts a video consultation with the authorised health practitioner and the client. Following this consultation, the authorised health practitioner and the RN discuss the management and required medicines which the RN is then able to prescribe to enable the client to begin treatment immediately. The RN ensures the client's health record is updated to reflect the agreed approach to care. Follow up with the client is arranged with the authorised health practitioner at their next clinic visit as per the clinical governance framework and policy of the health organisation so that the RN can provide feedback and effectiveness of treatment can be evaluated.

Example 4

A designated RN prescriber working in a cardiology unit of a hospital admits a patient from the ED with hypertension. The RN is able to prescribe under the latest hospital guidelines, clinical governance framework and policy of the hospital for RN prescribers to treat hypertension. In the guidelines there are set parameters that must be met including safety and screening so that the RN can prescribe certain anti-hypertensive medications to the patient on admission to the unit. The designated RN prescriber discusses the treatment plan and management of the patient with the authorised health practitioner and patient.

Impacts of Option 2

It is difficult to undertake a full economic cost-benefit analysis of options in relation to RNs expanding their scope of practice to prescribe scheduled medicines, because the costs and benefits of social economic impacts can be challenging to quantify. As such the following consultation questions are designed to obtain further advice on the potential costs and benefits associated with all of the options presented and will inform the final Decision: Regulation Impact Statement.

Impact on consumers

The predicted impact for consumers is that they may have improved access to timely and effective healthcare, particularly for those in rural and remote areas, aged care and vulnerable cohorts such as such as Aboriginal and Torres Strait Islander Peoples as the prescribing agreement between the RN prescriber and the authorised health practitioner has the potential to improve the coordination of care for consumers.

Impact on governments

To give effect to designated RN prescribing, each state and territory would need to review and likely amend their respective drugs and poisons legislation. They may also need to create a requirement for the development of policies and guidance for public health services. Both of these activities will include a time and cost impost and the NMBA would welcome the views of governments and health organisation/services on this.

Under Option 2, the NMBA anticipates that there would not be a net increase in the number of medicines prescribed as the consumer would have previously have the medicines prescribed by a medical practitioner or a nurse practitioner. There may be a financial cost to consumers for medicines prescribed by an RN if the medicines are not subsidised by the Pharmaceutical Benefits Scheme (PBS). There is a potential risk of fragmentation of healthcare if the RN prescriber and the authorised health practitioner do not take a coordinated approach to the provision of care. This could be mitigated through the development of a prescribing agreement that is required as a part of the proposed model of prescribing.

Impact on health practitioners and health organisations/services

Health services seeking to introduce designated RN prescribing would have to develop a governance framework. There may be a time impost in putting in place a medicines advisory committee, and all other components required of the governance framework.

There are several potential financial and time costs for health practitioners and health services if they decide to establish a designated RN prescribing model, for:

- establishing the model including the governance framework, prescribing agreements and monitoring of prescribing by RNs.
- supporting RNs to meet the requirements of the proposed registration standard, and in particular the required education.

- education of other health practitioners about the role that they play in the model.
- potential increase their insurance premiums as a result of enabling RNs to prescribe
- Increased cost in wage for designated RN prescribers may outweigh the benefits depending on the size of the health service. This would be subject to a cost benefit analysis undertaken by the individual health service and the NMBA would welcome the view of stakeholders as per the consultation questions

Health services that decide to implement the proposed model of prescribing and employ designated RN prescribers may see an improved ability to provide timely access and better coordinated care to consumers. For hospitals, there may be reductions in length of stay for inpatients and therefore cost of care. The ability for designated RN prescribers to provide care to certain patients has the potential to free up health practitioners to focus on more complex patients which leads to a more effective use of resources.

There will be no impact to the current prescribing practices by NPs and medical practitioners as they work under a different prescribing pathway.

Access to GPs in residential aged care facilities can be difficult and can result in delayed treatment and unnecessary hospital presentations. If designated RN prescribers are employed in areas such as aged and community care, there is a potential for this to lead to reductions in presentations to hospitals for treatment.

Impact to registered nurses

Education costs − while the details of the RN prescribing education is yet to be fully determined, the current cost for the post graduate midwifery prescribing program of study is $3,450, and it is anticipated that the cost for an RN prescribing program of study would be similar.

Endorsement costs − approximately $175 for applying to the NMBA for the endorsement.

Insurance costs – The NMBA's *Registration standard: Professional indemnity insurance arrangements* outlines the insurance requirements for nurses and midwives. Where RNs are employed by a health service, employers generally have PII arrangements in place that provide cover for practice. However, RNs can seek out discretionary PII cover in their own name as part of membership of a professional body or trade union if desired. For designated RN prescribers, PII arrangements would need to include the prescribing activities undertaken within their of scope of practice under the partnership agreement. A review of current insurance premiums for RNs through membership or affiliation links indicates that the annual cost to the RN is currently $500.

Ongoing compliance – One of the NMBA's ongoing compliance requirements is continuing professional development (CPD). For designated RN prescribers an additional 10 hours of CPD relevant to the area of prescribing of scheduled medicines is required in accordance with the *Registration standard: Continuing professional development*. The cost will be dependent on the individual RN and the types of CPD they choose to undertake. For example, attending a conference is likely to attract an increased costs as opposed to accessing journals within the workplace or attending designated RN prescribing education provided by their employer.

Benefits – research (Australian and international) indicates that RNs who are educated and authorised to prescribe medicines have improved work satisfaction, improved collegiality with other health practitioners and increased career opportunities which enhance positively on retention.

Consultation questions

9. **Are there any other benefits or costs associated with Option 2?**
10. **Are there any unintended consequences with Option 2?**
11. **What impacts will Option 2 have for relevant markets, including impacts on prices and competitions?**
12. **Are there any costs that have not been identified?**
13. **Are there any hidden costs?**
14. **Have the costs been accurately identified for RNs and current prescribers?**
15. **What impacts could Option 2 have on current prescribers?**
16. **Do you believe that Option 2 would improve access to healthcare for consumers?**
17. **Do you agree or disagree with the impacts that have been described?**
18. **Are there any risks associated with Option 2 that have not been identified?**
19. **What is the perceived the cost-benefit analysis for Option 2?**

Option 2 (a): enable RNs to expand their scope of practice to prescribe Schedule 2, 3, and 4 medicines only under designation/supervision

During the development of the proposed model of prescribing and earlier consultation with stakeholders, consideration was given to whether an endorsement should extend to Schedule 8 medicines.

Some stakeholders raised concerns about the inclusion of Schedule 8 medicines due to the higher risk profile of these medications.

There was also feedback from key stakeholders, health services and RNs that for the model to achieve its full potential of safe, timely and effective access to healthcare for consumers, Schedule 8 medicines needed to be included, especially in areas of practice such as palliative care, community, rural, remote and emergency areas.

In response to these concerns Option 2a proposes that the new standard could be limited to prescribing only Schedule 2, 3 and 4 medicines. This option would otherwise include all the requirements described in Option 2.

Impacts of Option 2(a)

According to the Therapeutic Goods Administration (TGA), since 2009 there has been a steady increase in the prescribing of opioids in Australia. With levels of prescription opioid overdose at record levels in Australia and internationally, the TGA in 2018 determined that prescription opioid products will only be available via prescription from a doctor or nurse practitioner. In addition, to reduce the harms and deaths from prescription medicines, the Victorian Government has introduced Safe Script. This is a database which monitors the prescribing of Schedule 8 medicines in real time and enables health practitioners to make safer clinical decisions about prescribing.

Limiting designated RN prescribing to Schedule 2, 3 and 4 medicines could reduce the risks associated with prescribing Schedule 8 and prescription opioid medicines.

The impacts to consumers will be similar to Option 2, with the exception of people who require Schedule 8 medicines, such as those receiving palliative care. These consumers would likely need to have their medicines always prescribed by a medical practitioner or nurse practitioner, which has the potential to result in fragmented care. In addition, the potential for improved access to care, particularly for people in rural and remote locations and disadvantaged groups could not be fully realised.

Impacts to health services, governments and RNs would be the same as Option 2.

There may be additional costs to health services and career progression costs to RNs in areas such as palliative care that would acquire less benefit if designated RN prescribers are unable to prescribe Schedule 8 medicines. It may increase their costs because they will continue to require a medical practitioner or nurse practitioner to prescribe these, as well as the designated RN prescriber for other medicines.

Option 2 (b): enable RNs to expand their scope of practice to prescribe Schedule 2, 3, 4 and 8 medicines only under designation/supervision except for RNs working in private practice or as a sole practitioner

The NMBA received feedback through earlier consultation that the proposed governance framework may not be sufficient to address the risk posed where designated RN prescribers may be working in isolation, and the impact this may have on public safety, especially where RNs are working privately and/or performing cosmetic procedures.

In response to these concerns, the new standard could be limited to RNs working in public healthcare settings, primary care and general practice for the first three years following its approval, to enable the standard to be established, embedded and evaluated.

Impacts of Option 2(b)

The impacts of Option 2(b) are the same to that of Option 2. Some additional anticipated costs of Option 2(b) are that for some people not being treated in a public facility or general practice:

- there may not be improved access to timely care
- there is a potential for fragmented care and
- impacted people will be required to have their medicines continued to be prescribed by a nurse practitioner or medical practitioner.

The additional benefit of Option 2(b) is that RNs working in isolation or in areas that are considered higher risk, such as cosmetic injectables, would not be able to apply for the endorsement until it had been tested in public facilities or general practice, thus reducing the risk of adverse outcomes for consumers.

Impact to RNs

In addition to the costs associated with Option 2, under this model there is an opportunity cost to RNs who work in private practice or are self-employed, because they would not be able to apply for the endorsement, potentially limiting opportunities to develop their business.

Impact to health practitioners and health services

There would be an opportunity cost to health practitioners working in private practice because they would be unable to realise potential benefits of using designated RN prescribers within their business model.

The potential benefit of this option for health practitioners in private practice is that there would be no competition for business from RN prescribers.

Consultation questions

20. **Are there any other benefits or costs associated with Options 2(a) or 2(b)?**
21. **Are there any unintended consequences with Options 2(a) or 2(b)?**
22. **What impacts will Options 2(a) or 2(b) have for relevant markets, including impacts on prices and competitions?**
23. **What impacts would Options 2(a) or 2(b) have on current prescribers?**
24. **Do you believe that Options 2(a) or 2(b) would improve access to healthcare for consumers?**
25. **Which option do you think would improve equity of access to healthcare for all consumers? Option 1, Option 2, Option 2(a) or Option 2 (b)**
26. **Are there other options not presented that could address the problems identified?**

Section 6

Who has been consulted to date and how has their feedback been incorporated?

The National Law requires the NMBA to ensure there is wide-ranging consultation on the content of any proposed new standard, code or guideline.

The NMBA usually undertakes a minimum of two rounds of consultation:

1. Preliminary consultation with key stakeholders − enables the NMBA to test its proposals and refine before proceeding to public consultation and seeking the views of all interested stakeholders.
2. Public consultation − sent to stakeholders including government, professional associations, complaint entities, consumer groups and the other National Boards. Public consultation papers are also available on the NMBA's public website for download by registrants, patients and any other interested members of the public. Anyone may make a submission and the NMBA reviews all feedback received. Documents are available for public consultation for a minimum of eight weeks.

The NMBA has undertaken comprehensive preliminary research and earlier consultation on the potential expansion to the scope of practice of RNs to prescribe scheduled medicines through the proposed *Registration standard: Endorsement for scheduled medicines − designated registered nurse prescriber*.

The summary provided (at Appendix C) demonstrates that since 2017, the NMBA has undertaken extensive consultation on this proposed model of prescribing for RNs with governments, key nursing and other relevant health stakeholders, nurses and consumers. As a part of this process the NMBA has further identified that challenges with access to healthcare services, the impact of an ageing population and the increasing level of chronic and complex diseases are placing greater demand on available health services. The proposal to extend the RN scope of practice to designate RN prescribers can assist in addressing these issues and provide increased benefits to the professional role of the RN workforce

Conclusion

As illustrated in this C-RIS, there is increasing demand for acute and chronic care services across the spectrum in both hospital and community settings and it has been reported that even countries with the most comprehensive healthcare systems will experience service gaps which will cause disparities in healthcare outcomes.

Many countries have already embraced innovative prescribing models for RNs. Australian government, policy makers, health departments, organisations and health workforce should support extending scopes of practice such as RN prescribing in order to produce a more flexible, sustainable and responsive workforce that improves the quality and safety of care and effectively meets the current and ongoing issues and challenges across healthcare. Enhancing the role of the RN will also enable RNs to work to their full scope of practice while contributing to workforce capacity and sustainability. [36]

The NMBA will review all stakeholder feedback and any additional evidence received from this public consultation to inform the NMBA's decision about whether to proceed with one of the proposed or suggested options. Only then will the Board finalise its policy position incorporating this feedback and evidence to prepare the Decision RIS and potentially recommend that the Ministerial Council for the National Scheme approve a registration standard.

Consultation process

The NMBA invites you to provide feedback to the consultation questions provided within the C-RIS. Your responses will assist us in understanding the costs, benefits and impacts of the proposed options and how the proposed *Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber* will work in practice.

A complete list of the consultation questions is provided at the end of the document.

You can participate by:

- completing the online survey or
- emailing your responses (word document format only) to nmbafeedback@ahpra.gov.au

The closing date for feedback is **Friday 28 July 2023**.

Publication of submissions

The NMBA publishes submissions on its website to encourage discussion and inform the community and stakeholders. However, the NMBA will not publish on its website, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the consultation.

Before publication of submissions, the NMBA may remove personally identifying information including contact details. The views expressed in the submissions are those of the submitting individual or organisation and publication does not imply any acceptance of, or agreement with, these views by the NMBA.

The NMBA accepts submissions made in confidence. These submissions will not be published on the website or elsewhere. Submissions may be confidential because they include personal experiences or other sensitive information. Any request for access to a confidential submission will be determined in accordance with the Freedom of Information Act 1982 (Commonwealth), which has provisions designed to protect personal information and information given in confidence.

Please let the NMBA know if you do not want your submission published or want all or part of it treated as confidential.

All information collected will be treated confidentially and anonymity preserved in internal and published reports of survey results. Data collected will only be used for the purposes described above.

Your participation is entirely voluntary.

If you have any questions, you can contact the NMBA at nmbafeedback@ahpra.gov.au

Your privacy

The NMBA is subject to the Privacy Act 1988 (Cth) (Privacy Act) and is committed to protecting your personal information. The Australian Health Practitioner Regulation Agency's (Ahpra) Privacy Policy provides information on accessing and correcting your personal information and the Ahpra complaints process for any privacy breach.

List of consultation questions

1. Do you agree or disagree with the problems that have been identified?
2. What effects do you think these problems could have on people accessing healthcare?
3. Do you have any information, analysis or data that is relevant to the issues being discussed?
4. Are there any other problems that you think should be considered as a part of this Consultation regulation impact statement (C-RIS)? If so, please describe what these are and how these problems should be addressed
5. Are there any additional options that have not been identified?
6. What are the costs and benefits costs and benefits associated with retaining the status quo as identified by the Board?
7. Are there other costs and benefits associated with retaining the status quo that the Board has not identified?
8. Do you agree or disagree with the costs and benefits associated with retaining the status quo?
9. Are there any other benefits or costs associated with Option 2?
10. Are there any unintended consequences with Option 2?
11. What impacts will Option 2 have for relevant markets, including impacts on prices and competitions?
12. Are there any costs that have not been identified?
13. Are there any hidden costs, related to PII etc
14. Have the costs been accurately identified for RNs and current prescribers?
15. What impacts would Option 2 have on current prescribers?
16. Do you believe that Option 2 would improve access to healthcare for consumers?
17. Do you agree or disagree with the impacts that have been described?
18. Are there any risks associated with Option 2 that have not been identified?
19. What is the perceived the cost-benefit analysis for option 2?
20. Are there any other benefits or costs associated with Options 2(a) or 2(b)?
21. Are there any unintended consequences with Options 2(a) or 2(b)?
22. What impacts will Options 2(a) or 2(b) have for relevant markets, including impacts on prices and competitions?
23. What impacts would Options 2(a) or 2(b) have on current prescribers?
24. Do you believe that Options 2(a) or 2(b) would improve access to healthcare for consumers?
25. Which option do you think would improve equity of access to healthcare for all consumers? Option 1, Option 2, Option 2(a) or Option 2 (b)
26. Are there other options not presented that could address the problems identified?

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Appendix A: Proposed registration standard

Registration standard

Endorsement for scheduled medicines − designated registered nurse prescriber

Effective from: <<<date>>>

Summary

This registration standard describes how a registered nurse (RN) can qualify for this endorsement for scheduled medicines under section 94 of the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law). This registration standard sets out the scope of the endorsement − Designated registered nurse prescriber (designated RN prescriber) and what the Nursing and Midwifery Board of Australia (NMBA) expects of RNs to attain and retain this endorsement.

Does this standard apply to me?

This registration standard applies to RNs:

- applying[1] for the endorsement for scheduled medicines as a designated RN prescriber, and/or
- whose registration is endorsed for scheduled medicines as a designated RN prescriber.

Scope of endorsement

A designated registered nurse prescriber is qualified to **administer, obtain, possess, prescribe, supply** and/or **use** Schedule 2, 3, 4 and 8 medicines with an authorised health practitioner, in accordance with this standard and associated guidelines and relevant state and territory legislation, for the purposes of practice of nursing.

The requirements of the endorsement

When applying for the endorsement for scheduled medicines − designated RN prescriber, an RN must be able to demonstrate all of the following:

1. Current general registration as an RN in Australia with no conditions or undertakings relevant to this endorsement.
2. The equivalent of three years' full-time post initial registration clinical experience (5,000 hours) within the past six years, from the date when the complete application seeking endorsement as a designated RN prescriber is received by the NMBA.
3. Successful completion of:
   a) NMBA-approved units of study leading to endorsement for scheduled medicines as a designated RN prescriber, or
   b) units of study that are equivalent to the NMBA-approved units of study leading to endorsement for scheduled medicines as a designated RN prescriber.

[1] Applications for endorsement may be made by registered nurses who hold registration with the NMBA or persons that are in the process of applying for registration as a registered nurse with the NMBA. Registration as a registered nurse must be granted before the endorsement can be granted

What must I do when I am endorsed?

Ongoing endorsement by the NMBA is contingent upon the designated RN prescriber complying with the following requirements:

1. NMBA *Guidelines for registered nurses applying for or with endorsement for scheduled medicines – designated registered nurse prescriber* particularly the requirements of the prescribing relationship with the authorised health practitioner/s and the governance framework.
2. For the first six months of the endorsement the designated RN prescriber must undertake a period of clinical mentorship with an authorised health practitioner.
3. Must only prescribe when there is an active prescribing arrangement in place with an authorised health practitioner.
4. For sole practitioners and/or RNs working in private practice the additional requirements outlined in the NMBA *Guidelines for registered nurses applying for or with endorsement for scheduled medicines – designated registered nurse prescriber* must also be met.

At renewal of registration

When you apply to renew your registration, you need to declare that you comply with the ongoing requirements for endorsement as set out above.

Under section 109 of the National Law, designated RN prescribers are required to make an annual declaration that they have met the professional indemnity insurance and recency of practice requirements and completed the required continuing professional development (CPD), including an additional 10 hours of CPD related to prescribing of scheduled medicines.

During the registration period

Your compliance with this registration standard, guidelines and all other relevant NMBA documents may be audited from time to time or if the NMBA receives a notification about you that is relevant to this endorsement.

Evidence

You must retain relevant records as evidence that you meet the ongoing requirements of this registration standard in case you are audited.

What happens if I don't meet this standard?

If you don't meet the requirements of this registration standard and guidelines you will not be eligible for initial or ongoing endorsement as a designated RN prescriber.

The National Law establishes possible consequences if you do not meet the ongoing requirements of this registration standard and guidelines, including that:

- the NMBA can impose conditions on your registration and/or endorsement or refuse renewal of registration and/or endorsement (sections 82 and 112 of the National Law).

Registration standards, codes or guidelines may be used in disciplinary proceedings against you as evidence of what constitutes appropriate practice or conduct, for the nursing profession (section 41 of the National Law).

Guidelines

The NMBA *Guidelines for registered nurses applying for or with the endorsement for scheduled medicines − designated registered nurse prescriber* provide information about what the NMBA expects of you when you are applying for endorsement and when you are endorsed.

You are expected to understand, apply and comply with these guidelines, particularly the requirements of the prescribing relationship with the authorised health practitioner/s and the governance framework, together with this registration standard.

State or territory authority

The endorsement of your registration indicates that you are qualified to administer, obtain, possess, prescribe, supply and/or use Schedule 2, 3, 4 and 8 medicines specified in the endorsement but does not authorise you to do so.

The authorisation for you to administer, obtain, possess, prescribe, supply and/or use the Schedule 2, 3, 4 and 8 medicines in a state or territory will be provided by or under legislation of the state or territory.

You must administer, obtain, possess, prescribe, supply and/or use Schedule 2, 3, 4 and 8 medicines in the accordance with the state or territory legislation at all times.

Wording to appear on the Register of nurses

Endorsed as qualified to administer, obtain, possess, prescribe, supply and/or use Schedule 2, 3, 4 and 8 medicines for the purposes of prescribing as a designated registered nurse prescriber with an authorised health practitioner within the scope of registered nurse practice.

Authority

The Ministerial Council has decided that the NMBA may endorse RNs to the extent described in this registration standard.

This standard has been approved by the Ministerial Council under section 12 of the National Law on <<date>>.

Registration standards are developed under section 38 of the National Law and are subject to wide-ranging consultation.

Definitions

Active prescribing agreement means a prescribing agreement (as defined in the NMBA *Guidelines for registered nurses applying for or with the endorsement for scheduled medicines - as a designated registered nurse prescriber*) where there is a current relationship with the authorised health practitioner.

Approved units of study means the educational units of study to develop an RN's knowledge and skills in prescribing medicines that has been accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and approved by the NMBA under section 49(1) of the National Law for the purpose of enabling the RN to seek endorsement, under section 94 of the National Law, to prescribe Schedule 2, 3, 4 and 8 medicines, in accordance with relevant state and territory legislation.

Authorised health practitioner is a registered health practitioner who is an authorised autonomous prescriber − for example a medical practitioner or a nurse practitioner (more than one authorised health practitioner may work with the designated RN prescriber).

Designated registered nurse prescriber means an RN with an endorsement for scheduled medicines who undertakes prescribing within their level of competence and scope of practice together with an authorised health practitioner. The designated RN prescriber is responsible and accountable for prescribing within their scope of practice and authorisation. The designated RN prescriber has an authorisation to prescribe medicines that is determined by legislation, will meet the requirements of the NMBA related to the endorsement and policies of the jurisdiction, employer or health service.

Ministerial Council means the Council of Australian Government (COAG) Health Council.

National Law means the Health Practitioner Regulation National Law as in force in each state and territory.

Person or people refers to those individuals who have entered into a therapeutic and/or professional relationship with an RN. These individuals will sometimes be healthcare consumers, at other times they may be colleagues or students, this will vary depending on who is the focus of practice at the

time. Therefore, the words person or people include all the patients, clients, consumers, families, carers, groups and/or communities, however named, that are within the RN's scope and context of practice.

Prescribe a medicine for the purpose of this endorsement means to authorise the supply and/or administration of a medicine to a person (for example, an RN who writes a prescription for a person to be dispensed by a pharmacist is exercising their authority to prescribe) – it also includes de-prescribing of medicines.

Sole practitioner or individual working in private practice means the RN is working in a business owned solely by the RN or in a partnership or collective; or where an RN or is employed (full-time or part-time) by a company that is owned solely by the RN, or that is owned solely by RNs, where the only directors of that company are registered nurses.

Supply a medicine means to provide a medicine to a person for their later use or administration (for example, a nurse in a hospital in a rural and remote area who is authorised to supply a medicine to a person to take home for self-administration is exercising their authority to supply).

Administer a medicine means to personally apply or introduce a medicine, or personally observe its application or introduction, to the person's body.

The terms 'obtain' and 'possess' should be given their ordinary dictionary meaning.

Scheduled medicine means a substance included in a schedule to the current Poisons Standard within the meaning of the *Therapeutic Goods Act 1989* (Cth).

Review

This standard for endorsement of registration will be reviewed from time to time as necessary. The NMBA will review this standard at least every <<five>> years.

Appendix B: Proposed guidelines

Guidelines

For registered nurses applying for and with the endorsement for scheduled medicines − designated registered nurse prescriber

Effective from: <<<date>>

Introduction

These guidelines provide information about how to meet the Nursing and Midwifery Board of Australia (NMBA) requirements when you are applying for an endorsement for scheduled medicines as a designated registered nurse (RN) prescriber (designated RN prescriber) and when you are endorsed as a designated RN prescriber. You are expected to understand and apply these guidelines together with the *Registration standard: Endorsement for scheduled medicines − designated registered nurse prescriber* (the registration standard).

The NMBA will audit compliance with the requirements of these guidelines. You should retain relevant evidence that you meet the requirements of these guidelines.

What is designated prescribing?

Designated prescribing occurs when an RN with the endorsement for scheduled medicines − designated RN prescriber undertakes prescribing within their level of competence and scope of practice in partnership with an authorised health practitioner[1]. The designated RN prescriber is responsible and accountable for prescribing within their scope of practice and authorisation. The designated RN prescriber has an authorisation to prescribe medicines that is determined by legislation, will meet the requirements of the NMBA related to the endorsement and the policies of the jurisdiction, employer or health service.

Do these guidelines apply to me?

These guidelines apply to RNs:

- applying[1] for the endorsement for scheduled medicines as a designated RN prescriber, and/or
- whose registration is endorsed for scheduled medicines as a designated RN prescriber.

Summary

These guidelines help you to understand:

1. the endorsement application requirements
2. the clinical mentoring requirements
3. your responsibilities in working in accordance with a governance framework
4. the requirements of designated prescribing including the responsibilities and accountabilities of the endorsed RN and the authorised health practitioner, and

[1] An authorised health practitioner is a registered health practitioner who is an authorised autonomous prescriber for example a medical practitioner or a nurse practitioner (more than one authorised health practitioner may work with the designated registered nurse prescriber).

[2]Applications for endorsement may be made by registered nurses who hold registration with the NMBA or persons that are in the process of applying for registration as a registered nurse with the NMBA. Registration as a registered nurse must be granted before the endorsement can be granted.

5. safe and effective prescribing - what you need to do to administer, obtain, possess, prescribe, supply and/or use scheduled medicines when prescribing.

Applying for the endorsement

You must be able to demonstrate that you meet the following requirements of the registration standard at the time of your application for endorsement*:*

1. Current general registration as an RN in Australia with no conditions or undertakings relevant to this endorsement.
2. The equivalent of three years' full-time post initial registration clinical experience (5,000 hours) within the past six years, from the date when the complete application seeking endorsement as a designated RN prescriber is received by the NMBA.
3. Successful completion of:
    a) NMBA-approved units of study leading to endorsement for scheduled medicines as a designated RN prescriber, or
    b) units of study that are equivalent to the NMBA-approved units of study leading to endorsement for scheduled medicines as a designated RN prescriber.

With respect to three years' full-time post initial registration clinical experience (5,000 hours), it is likely that some of the clinical experience, knowledge, skills and attributes of the RNs seeking endorsement will be in a specific area of practice to prescribe – this may include formal post graduate qualifications relevant to the area in which the RN practises.

The evidence that you will need to provide when applying for the endorsement for scheduled medicines as a designated RN prescriber is provided at Appendix D.

1. The requirements of designated prescribing

Scope of endorsement

The scope of the endorsement for scheduled medicines as a designated RN prescriber indicates that a designated RN prescriber is qualified to **administer, obtain, possess, prescribe, supply** and/or **use** Schedule 2, 3, 4 and 8 medicines with an authorised health practitioner, in accordance with this standard and associated guidelines and relevant state and territory legislation, for the purposes of practice of nursing.

Clinical mentorship

Once you are endorsed you will be required to complete a six-month period of clinical mentorship with an authorised health practitioner. The period of clinical mentorship is an important component of the establishment of the designated prescribing model.

The education programs for an RN to become qualified to prescribe will ensure that the RN is competent to prescribe scheduled medicines within their scope of practice. The purpose of clinical mentorship is to enable the designated RN prescriber to develop confidence in prescribing. The role of the mentor is to provide the designated RN prescriber with support in developing the confidence to prescribe.

The governance framework

To enable the model of designated prescribing to be flexible and responsive, whilst also protecting the public, a governance framework is to be established by organisations. Health services and employers are best placed to develop and approve governance frameworks for this designated prescribing model as they have established governance frameworks in accordance with National Safety and Quality Health Service Standards (NSQHSS). Health services also understand organisational functions and service needs. This provides the foundation for balance between registration requirements, protecting the public and safety and quality of prescribing practices. The designated RN prescriber and the authorised health practitioner will work in accordance with a clinical governance framework. The clinical governance framework will build on the existing established governance frameworks for the quality use of medicines of the employer organisation to establish the client groups and scope of prescribing of the designated RN prescriber.

It is the employer's responsibility together with the designated RN prescriber and authorised health practitioner to ensure there is an appropriate clinical governance framework in place to support the model of prescribing. State and territory health departments and/or employer organisations will have governance frameworks that comply with Quality use of Medicines (QUM). When implementing the designated prescribing model these may need to be reviewed in order to ensure that the introduction of this new model of prescribing is adequately covered. Some elements of the governance framework may include:

- a multidisciplinary medicines advisory committee to provide expert advice and guidance on designated prescribing policies, guidelines and procedures
- establishment/approval of the medicines the designated RN prescriber is authorised to prescribe, and to provide for its constant review; where Schedule 8 medicines are included specific details must be outlined within the prescribing agreement including a risk analysis
- development of the prescribing agreement, the prescribing agreement must include details of the initial clinical mentorship
- development of local and/or organisational policies related to designated RN prescribing
- risk management systems and processes for adverse event reporting, incident reporting, reporting of near misses and medication errors
- processes for monitoring, review and audit of prescribing practices
- processes for communicating the prescribing agreement with other health practitioners and consumers, and
- processes for resolving or escalating differences of opinions.
- the governance framework to be reviewed on a regular basis.

To note, the governance framework is not a prerequisite for endorsement by the NMBA. It is, however a requirement for designated RN prescribing.

2. Prescribing relationship

A designated RN prescriber and authorised health practitioner work together in partnership in the provision of healthcare.

The RN endorsed as a designated RN prescriber is educated to make diagnostic and treatment decisions within their level of competence and scope of practice. The designated RN prescriber will be able to prescribe scheduled medicines in accordance with the governance framework. In line with professional practice expectations, the designated RN prescriber will be responsible for seeking guidance and/or referring people when their care is outside their agreed governance framework or scope of practice. The designated RN prescriber is responsible and accountable for the prescribing decisions they make, and actions taken.

The authorised health practitioner is responsible for working with the designated RN prescriber in accordance with the governance framework. The authorised health practitioner must be aware of the designated RN prescriber's scope of practice with regards to prescribing and ensure their scope and area of practice align with the designated RN prescriber's scope of prescribing. The authorised health practitioner is expected to work in partnership with the designated RN prescriber and collaborate with the RN when the people in their care are outside the designated RN prescriber's scope of practice. It is the responsibility of the designated RN prescriber to recognise when care of the person is outside their scope of practice and to refer that person to the authorised health practitioner or other relevant health practitioner in a timely and effective manner.

The prescribing agreement

The prescribing agreement is a key document for the designated prescribing model. This is a written agreement between the designated RN prescriber and the authorised health practitioner and approved by the health organisation/service or employer. This should be retained and stored by the health organisation/service or employing organisation, reviewed regularly, and be subject to audit by the NMBA. Details of the prescribing arrangement must clearly document the role of both the designated RN prescriber and the authorised health practitioner. The prescribing authority may vary according to the

health organisation/venue, prescribing agreement and the specific clinical context of its application and must include:

- roles and responsibilities of both the designated RN prescriber and authorised health practitioner
- clients and/or conditions within the scope of prescribing practice of the designated RN prescriber
- medical conditions for which the designated RN prescriber has authority to prescribe
- medicines that the designated RN prescriber is authorised to prescribe; where Schedule 8 medicines are included specific details must be outlined including a risk analysis
- responsibility for aspects of care regarding diagnosis and associated prescribing
- clearly documented processes for consultation and referral including provisions where proximity and/or availability of the authorised health practitioner to the designated RN prescriber may need consideration
- arrangements where the agreement is with multiple authorised health practitioners
- a plan for regular review (at least annually)
- a process for monitoring and audit of designated RN prescribing
- processes for resolving or escalating of differences of opinions

The prescribing agreement should also be amended to reflect any changes affecting the designated RN prescriber and/or authorised health practitioner as required.

Accountabilities of the designated RN prescriber

The designated RN prescriber is accountable for prescribing within their scope of practice. In addition to complying with organisational policies and/or procedures the designated RN prescriber must:

- understand their level of prescribing competence
- work with the authorised health practitioner to establish the prescribing agreement
- only prescribe medicines as agreed within the prescribing agreement
- not prescribe medicines unless there is an active prescribing agreement in place
- consult and refer to the authorised health practitioner or other relevant health practitioner(s) when person(s) being cared for are outside their scope of practice
- participate in regular reviews (at least annually) of the prescribing agreement
- participate in monitoring and audit related to prescribing practice, and
- comply with all relevant NMBA standards, codes, and guidelines.

For RNs working as a sole practitioner or individuals in private practice

Designated RN prescribers who work outside the routine governance arrangements of a health service provider are required to work in accordance with the above requirements as well as the additional requirements described in Appendix E.

Accountabilities of the authorised health practitioner

The authorised health practitioner is expected to work in collaboration with the designated RN prescriber, the responsibilities of the authorised health practitioner include:

- understanding the scope of prescribing practice of the designated RN prescriber
- working with the designated RN prescriber to establish the prescribing agreement
- clinical mentoring with the designated RN prescriber for the first six months of endorsement
- effectively collaborate with and accept referrals from the designated RN prescriber when the person(s) being cared for are outside the RN's scope of practice
- participating in regular reviews (at least annually) of the prescribing agreement, and
- participating in monitoring and audit related to the designated RN prescriber.

3. Other requirements

Changes to scope of prescribing practice

The scope of practice for a designated RN prescriber may change over time. If the designated RN prescriber decides to expand or change their scope of practice, then the RN will need to complete further education requirements and/or skill development relevant to the new area of practice.

Designated RN prescribers planning to change scope are required to use the NMBA's National framework for the development of decision-making tools for nursing and midwifery practice. This will ensure that designated RN prescribers are competent in their proposed expanded or new scope of practice.

It is responsibility of the designated RN prescriber, and where employed, an employer, to ensure that, should a designated RN prescriber be required to expand or change their scope of practice, that they have completed the relevant education and skill development.

Maintaining prescribing competence

The NMBA *Recency of practice registration standard* and *Continuing professional development registration standard* apply equally to the designated RN prescriber. This means that designated RN prescribers are required to demonstrate recency of practice relevant to the endorsement to prescribe when they renew their annual registration and complete an additional ten (10) hours of continuing professional development related to prescribing and QUM annually.

Professional indemnity insurance

The designated RN prescriber and authorised health practitioner must comply with the requirements of the *Professional indemnity insurance registration standar*d that is applicable to their profession. As such they are responsible for ensuring that their insurance arrangements cover all aspects of their practice.

Ongoing endorsement

Ongoing endorsement as a designated RN prescriber is contingent upon the RN meeting the NMBA's requirements for renewal of registration annually.

Under section 109 of the National Law, designated RN prescribers are required to make an annual declaration that they have met the professional indemnity insurance and recency of practice requirements and completed the required continuing professional development.

4. Safe and effective prescribing

Quality use of medicines

Designated RN prescribers must comply with *Quality Use of Medicines* (QUM), which is one of the central objectives of Australia's National Medicines Policy[3].

QUM means:

a. Selecting management options wisely by:

- considering the place of medicines in treating illness and maintaining health, and
- recognising there may be better ways than medicine to manage many disorders.

b. Choosing suitable medicines (if a medicine is considered necessary) so that the best available option is selected by taking into account:

- the individual
- the clinical condition
- risks and benefits
- dosage and length of treatment
- any coexisting conditions
- other therapies
- monitoring considerations, and
- costs for the individual, the community and the health system as a whole.

c. Using medicines safely and effectively to get the best possible results by:

- monitoring outcomes
- minimising misuse, over-use and under-use

[3] Australian Government. (2022). *National Medicines Policy* https://www.health.gov.au/resources/publications/national-medicines-policy

- improving people's ability to solve problems related to medicines, such as negative effects
- managing multiple medicines
- de-prescribing, and
- undertaking medicines reviews.

Adverse event reporting

Designated RN prescribers must report all suspected adverse events associated with medicines in accordance with organisational policies and/or procedures – this may include reporting to the Therapeutic Goods Administration (TGA).

The TGA is part of the Australian Government Department of Health, and is responsible for regulating therapeutic goods including medicines, medical devices, blood and blood products. The TGA also collects reports of adverse events associated with medicines and medical devices. Monitoring of adverse events allows the TGA to investigate and take action on medicines safety issues.

Further information can be found on the TGA website.

Medication errors

The NMBA's *Code of conduct for nurses* sets out the legal requirements, professional behaviour and conduct expectations for nurses. If a medication error is made the RN will be subject to local health service /organisational policy and procedures.

The Medication Safety Standard is one of the National Safety and Quality Health Service Standards. Health services must describe, implement and monitor systems to reduce the occurrence of medication incidents, and improve the safety and quality of medicines use. The Medication Safety Standard aims to ensure that health professionals safely prescribe, dispense and administer appropriate medicines, and monitor medicine use. The standard also aims to ensure that consumers are informed about medicines, and understand their own medicine needs and risks.

Prescriptions

A prescription is a legal document. It is a precise written instruction from a prescriber to a pharmacist for preparing and dispensing a drug for a person.

The designated RN prescriber has a duty of care to provide a prescription that is legible; this reduces the potential for errors in treatment. Computer generated prescriptions are generally more legible than those that are handwritten.

Regardless of the format of the prescriptions, designated RN prescribers need to check the details of the prescription for appropriateness, completeness and correctness.

The essential information needed for a legal prescription may vary between states and territories. Designated RN prescribers need to be aware of these variances if practising in different jurisdictions. The requirements generally include:

- prescribers name, address, telephone number and qualifications
- person's full name, address and date of birth
- date the prescription is written
- drug name in full
- drug strength
- drug form (e.g. tablet, capsule, or mixture)
- quantity of drug to be supplied
- drug dose, route of administration, frequency, and duration of treatment (if necessary)
- clear instructions for the person (in English) – it is not appropriate to write 'take as directed'
- any further instructions necessary for the pharmacist, and
- the signature of the prescriber in ink.

Pharmacist arrangements when external to a health service

When a prescription is written by a designated RN prescriber that is to be dispensed by a pharmacist that is external to the health service there must be clear written communication to the pharmacist informing

them of the prescribing arrangement including the medicines that the designated RN prescriber is authorised to prescribe.

Self-prescribing

The NMBA strongly recommends seeking independent and objective advice when you need healthcare, as there are risks associated with self-diagnosis and self-treatment. Designated RN prescribers must conform to relevant state and territory legislation in relation to self-prescribing.

Supply of scheduled medicines

The NMBA supports the view that the division of responsibility between a designated RN prescriber who prescribes a scheduled medicine and a pharmacist, who dispenses the scheduled medicine to the person, provides an important check designed to safeguard people.

The expertise of the pharmacist in counselling people is important in the follow-up care of the person. This includes checking adherence to the prescriber's instructions, confirming administration times and techniques, screening for adverse reactions and referring back to the prescriber for further investigations or advice when required.

In circumstances where the designated RN prescriber must also supply a scheduled medicine directly to a person, the supply process must meet the labelling and record-keeping requirements of the jurisdiction in which they are practising and the endorsed RN must provide counselling about the use of the medicine, its side effects and potential interactions and if available provide a *Consumer Medicines information leaflet*[4].

Working with other practitioners

Inherent in the registration standard is the requirement for the designated RN prescriber, when prescribing, to work in partnership with the authorised health practitioner. To ensure that the role and scope of practice of the designated RN prescriber is well understood it is critical that there are clear lines of communication between the designated RN prescriber, the authorised health practitioner and other members of the healthcare team including pharmacists.

Authority

The NMBA has developed these guidelines under section 39 of the National Law.

Guidelines approved by the NMBA may be used as evidence of what constitutes appropriate professional conduct or practice in proceedings against an RN under the National Law, or a law of a co-regulatory jurisdiction.

[4] Consumer Medicines information sheets are available at www.medicines.org.au.

Definitions

Active prescribing agreement means a prescribing agreement (as defined in the NMBA *Guidelines for registered nurses applying for or with the endorsement for scheduled medicines - as a designated registered nurse prescriber* where there is a current relationship with the authorised health practitioner.

Approved units of study means the educational units of study to develop a registered nurse's knowledge and skills in prescribing medicines that has been accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and approved by the NMBA under section 49(1) of the National Law for the purpose of enabling the RN to seek endorsement, under section 94 of the National Law, to prescribe Schedule 2, 3, 4 and 8 medicines, in accordance with relevant state and territory legislation.

Authorised health practitioner means a registered health practitioner who is an authorised autonomous prescriber for example a medical practitioner or a nurse practitioner (more than one authorised health practitioner may work with the designated RN prescriber).

Designated registered nurse prescriber means an RN with an endorsement for scheduled medicines who undertakes prescribing within their level of competence and scope of practice together with an authorised health practitioner. The designated RN prescriber is responsible and accountable for prescribing within their scope of practice and authorisation. The designated RN prescriber has an authorisation to prescribe medicines that is determined by legislation, will meet the requirements of the NMBA related to the endorsement and policies of the jurisdiction, employer or health service.

Ministerial Council means the Council of Australian Government (COAG) Health Council.

National Law means the Health Practitioner Regulation National Law as in force in each state and territory.

Person or people refers to those individuals who have entered into a therapeutic and/or professional relationship with a nurse. These individuals will sometimes be healthcare consumers, at other times they may be colleagues or students, this will vary depending on who is the focus of practice at the time. Therefore, the words person or people include all the patients, clients, consumers, families, carers, groups and/or communities, however named, that are within the nurse's scope and context of practice.

Prescribe a medicine for the purpose of this endorsement means to authorise the supply and/or administration of a medicine to a person (for example, a nurse who writes a prescription for a person to be dispensed by a pharmacist is exercising their authority to prescribe) – it also includes de-prescribing of medicines.

Sole practitioner or individual working in private practice means the RN is working in a business owned solely by the RN or in a partnership or collective; or where an RN or is employed (full-time or part-time) by a company that is owned solely by the RN, or that is owned solely by RNs, where the only directors of that company are registered nurses.

Supply a medicine means to provide a medicine to a person for their later use or administration (for example, a nurse in a hospital in a rural and remote area who is authorised to supply a medicine to a person to take home for self-administration is exercising their authority to supply).

Administer a medicine means to personally apply or introduce a medicine, or personally observe its application or introduction, to the person's body.

The terms 'obtain' and 'possess' should be given their ordinary dictionary meaning.

Scheduled medicine means a substance included in a schedule to the current Poisons Standard within the meaning of the *Therapeutic Goods Act 1989* (Cth).

Note: The NMBA and the Australian Health Practitioner Regulation Agency (Ahpra) operate in a co-regulatory model in some jurisdictions and may not be the only entities involved in undertaking assessment related to a notification. In co-regulatory definitions these terms may be described differently but have the same intent.

Review

The NMBA will monitor this guideline for effectiveness and review it at least every <<x>> years. Date of issue: <<insert date>>

Date of review: <<insert date>

Appendix C: Previous consultation by the NMBA

Date	Event	Overview and outcomes
2010	Commencement of the approved RIPEN standard	Ministerial Council in accordance with section 14 of the National Law, approves the NMBA's proposal for an endorsement in relation to scheduled medicines for registered nurses (rural and isolated practice)
Sep–Nov 2013	**Public consultation:** Proposed registration standard for endorsement of registered nurses and/or midwives to supply and administer scheduled medicines under protocol	The NMBA proposed to expand RIPEN to include midwives and to enable RNs other than those working in rural and isolated practice areas to be able to supply medicines under protocol. Feedback on the proposal was mixed and indicated that this endorsement was no longer required as the poisons legislation and associated policies in most jurisdictions facilitated the safe supply of medicines under protocol by RNs working in health services.
Apr–Jun 2015	**Preliminary consultation** Discontinuation of the RIPEN standard	The NMBA consults on two options: Option 1 to maintain the status quo, Option 2 (preferred) to discontinue the registration standard. Six responses to this consultation were received. The feedback from this consultation was used to decide whether to further revise the consultation paper before, or after, public consultation.
Dec 2015–Feb 2016	**Public consultation:** Discontinuation of the RIPEN Standard (Option 2)	The overwhelming responses to the public consultation came from individuals and organisations in Queensland and Victoria, with very limited numbers of responses from national organisations nor from other jurisdictions. General feedback on the proposal was mixed and highlighted that, in fact, there remained little need for the standard. The majority of jurisdictions have relevant legislation and or policy to enable registered nurses to obtain, supply and administer scheduled medicines in accordance with protocols. While the majority of jurisdictions were not opposed to discontinuing the standard, two jurisdictions relied heavily on RIPEN and therefore its withdrawal did not receive unanimous support.
July 2016	**Exploratory literature review**	Comprehensive review of evidence-based research associated with medication prescribing and models of medication management by registered nurses and midwives. International literature review reveals that patients report high levels of acceptability of RN prescribing with evidence that some patients express a preference for nurse prescribing. RNs and midwife prescribers report increased job satisfaction and role autonomy from being granted the authority to prescribe. The review of related legislation in each jurisdiction reveals that while NP and midwife prescribing is autonomous, different mechanisms are in place to facilitate such prescribing. Recommendations include the development of a nationally accredited postgraduate RN prescribing curriculum aimed at developing RN competence to prescribe within specialist practice, or well-defined contexts of practice, as defined by the HPPP model 2 (prescribing under supervision).

Date	Event	Overview and outcomes
Oct 2016	**Intermediary measures** for expiry of RIPEN standard put in place	The Health Workforce Principal Committee (HWPC) recommends to the NMBA that the RIPEN standard be continued for two more years to enable the NMBA to work with the two jurisdictions (Queensland and Victoria) to develop a workable solution. HWPC also recommended that the NMBA work together with the Australian and New Zealand Council of Chief Nursing and Midwifery Officers (ANZCCNMO) to explore models of prescribing with or without protocol to determine a model for an endorsement to prescribing scheduled medicines for RNs.
March 2017	**Nurse and Midwife Prescribing Symposium** (Canberra)	National symposium organised by the Commonwealth Chief Nursing and Midwifery Officer (Australian Government Department of Health), designed to explore the potential for nurse/midwife prescribing in the Australian context. Overarching support for future models of RN/midwife prescribing to adopt an autonomous and a supervised approach rather than a single approach. Less support evident for an alternative outside of these models such as structured prescribing arrangement (HPPP model 3). Majority of respondents also feel that the common use of protocols currently in place across the majority of jurisdictions would be adequately governed through relevant jurisdictional policy or legislation without need for additional regulation by the NMBA.
Aug 2017	**Establishment of the ANZCCNMO/NMBA Prescribing Working Group**	Representatives from the Australian and New Zealand Council of Chief Nursing and Midwifery Officers (ANZCCNMO) and NMBA formed this working group.
Oct 2017	**Public consultation:** Registered nurse and midwife prescribing – Discussion paper	Wide-ranging public consultation exploring the possibility of RN and midwife prescribing rights. 62 responses mostly from organisations (n=40). Majority of respondents supported either autonomous and/or prescribing under supervised/designated prescribing.
Apr 2018	**Preliminary consultation:** Proposed registration standard: Endorsement for scheduled medicines for registered nurses prescribing in partnership	The feedback from this consultation was used to decide whether to further revise the consultation paper before, or after, public consultation
Jul–Sep 2018	**Public consultation:** Proposed registration standard: Endorsement for scheduled medicines for registered nurses prescribing in partnership	During the consultation period the NMBA held 11 information forums across all jurisdictions to engage and inform stakeholders regarding the public consultation process and provide an opportunity for feedback. Feedback could be provided either via a detailed written submission or via an online. 2,218 respondents completed the online survey as individuals while 37 responses were on behalf of an organisation. There was strong overall support for the proposal standard from both the written submissions and online survey responses (87.6% of online survey).
March 2019	**Profession-specific consultation**: Australian Medical Association (AMA) Royal Australian College of General Practitioners (RACGP)	The AMA supported the changes that are being proposed by the NMBA, including improved clarity of the relationship between the RN and the autonomous prescriber, change to 3 years post registration experience, more detail about the governance framework and stricter guidance about prescribing S8 medicines. The key issue of concern for the RACGP was the ability for the endorsed RN to work in partnership with a nurse practitioner as this would mean that a patient would potentially not have any interaction with a medical practitioner.

Date	Event	Overview and outcomes
Apr 2019	**Stakeholder forum** post public consultation Endorsement for scheduled medicines − designated registered nurse prescriber	This session provided key stakeholders with an update from the ANZCCNMO/NMBA Prescribing Working Group and feedback following the public consultation on the proposed endorsement for scheduled medicines. Key stakeholders were informed about the changes to the proposed registration standard and guidelines documents following public consultation feedback.
June 2019	**Consideration of proposed registration standard by** Ahpra Scheduled Medicines Expert Committee Endorsement for scheduled medicines − designated registered nurse prescriber	The role of the Scheduled Medicines Expert Committee (SMEC) within Ahpra is to advise National Boards on: the use of scheduled medicines generally, and matters relevant to a National Board's proposal for a new scheduled medicines endorsement or an amendment to an existing scheduled medicines endorsement. The SMEC was supportive of the NMBA's proposed registration standard guidelines and provided feedback to improve minor elements of both the submission paper, registration standard and guidelines.
Jul 2019	**Consideration by:** Jurisdictional Advisory Committee Endorsement for scheduled medicines − designated registered nurse prescriber	a majority of states and territories expressed in principle support for the proposal. Two jurisdictions expressed some concerns. There was common agreement across all jurisdictions regarding the need for a further risk assessment. One jurisdiction proposed that the NMBA stipulates that a risk analysis should be undertaken in order to understand the risks and benefits related to patient safety where RN prescribing is related to schedule 8 medicines.
Aug 2019	**Consideration by:** Scheduled Medicines Subcommittee (HSPC) Endorsement for scheduled medicines − designated registered nurse prescriber	Subcommittee was formed originally as a subcommittee of the Health Workforce Principal Committee (HWPC) of AHMAC, to address the need for and feasibility of a joint jurisdictional process for approving nationally consistent scheduled medicines authorities for the registered and unregistered health professions. With the dissolution of the HWPC as an AHMAC Principal Committee, the subcommittee continues under the auspices of the Health Services Principal Committee (HSPC). There was broad support for the standard where there are service gaps that would be best addressed through this model but suggested there was inadequate consideration and detail about the partnership arrangements.

Appendix D

Evidence model for registered nurses applying for Endorsement for scheduled medicines − designated registered nurse (RN) prescriber

Requirement	Evidence
Current general registration as an RN in Australia with no conditions or undertakings on registration relevant to the endorsement.	An applicant who is currently registered with the NMBA as an RN and whose registration does not have any conditions or undertakings imposed on their registration relevant to the endorsement. Evidence would be a current registration as reflected on the National register of nurses with no conditions or undertakings on the registration relevant to the endorsement.
The equivalent of three years' (5,000 hours) full-time post initial registration clinical experience within the past six years, from the date when the complete application seeking endorsement for scheduled medicines as a designated RN prescriber is received by the NMBA.	It likely that some of the clinical experience, knowledge, skills and attributes of the RNs seeking endorsement will be in a specific area of practice to prescribe – this may include formal post graduate qualifications relevant to the area in which the RN practises. RNs applying for endorsement need to submit: (a) Curriculum vitae (CV) detailing: • evidence of employment, clearly noting title and description of all clinical nursing practice with sufficient detail to determine three years' (5,000 hours) full-time post initial registration clinical experience • details of education and professional activities You must declare that the 'the CV is true and correct as at (insert date)'. This declaration must be signed and dated. For guidance on CV format refer to the Ahpra guidelines Standard format for curriculum vitae. (b) Certified copy of statement(s) of service which support the applicant's 5,000 hours clinical nursing practice within the past six years. The statement(s) of service must: • be on your employer's letterhead • be dated and signed by the Director of Nursing or equivalent. Self-employed nurses may provide a statutory declaration as their proof of service and • detail any periods of extended leave (e.g. long service leave or extended sick leave).

Successful completion of: • NMBA-approved units of study leading to endorsement for scheduled medicines as a designated RN prescriber, or • units of study that are equivalent to the NMBA-approved units of study leading to endorsement for scheduled medicines as a designated RN prescriber.	The NMBA has two pathways that fulfil the education requirements for endorsement for scheduled medicines as a designated RN prescriber. **Pathway 1** Evidence of successful completion of NMBA-approved units of study leading to endorsement for scheduled medicines as a designated RN prescriber **Pathway 2** Evidence of successful completion of units of study that are equivalent to the NMBA-approved units of study leading to endorsement for scheduled medicines as a designated RN prescriber as determined by the NMBA.

Submit relevant information

You are required to submit one copy of your application (complete with certified copies). Please ensure you keep an original copy for your own record.

Please do not include original documents in your application as it is retained by the Board.

All official documents such as certificates, transcripts and statement of service (including those that support claims in the curriculum vitae), letters from employers must be **certified copies**.

Further information regarding the certifying of documents is available on the Ahpra website

Applicants are required to complete the xx Application for endorsement for scheduled medicines for designated registered nurse prescriber form, which is located on the NMBA website, and attach this to their application.

You may submit your application form and documents in person to the Ahpra office in your state or by mail to GPO Box 9958 in your capital city.

Appendix E

Designated registered nurse prescribers who are working as sole practitioners or working in private practice

The NMBA acknowledges that some designated registered nurse prescribers (designated RN prescribers) will not be working in a direct employment relationship and may work in a contractual arrangement or may be self-employed and contract their services to an aged care facility or a community health service, for example.

The requirement for designated RN prescribers to work in accordance within a governance framework applies to all endorsed RNs regardless of their context of practice. To protect the public and provide designated RN prescribers who are sole practitioners or working in private practice with clarity and support to work safely the NMBA has established the below requirements that are **in addition** to the requirements of the governance framework

Designated RN prescribers who are sole practitioners or working in private practice are expected to have the following arrangements in place:

- clearly documented prescribing agreement with an authorised health practitioner
- documented medicines that have been agreed with an authorised health practitioner that the designated RN prescriber will prescribe
- clearly documented roles and responsibilities of both the endorsed RN and authorised health practitioner
- clearly articulated pathways for consultation and referral
- documented policies related to prescribing
- documented processes for the assessment and management of clinical risk, and
- processes for resolving or escalating of differences of opinions.

Designated RN prescribers who are working as sole practitioners or working in private practice must practice in accordance with the NMBA's *Code of conduct for nurses*, *Registered nurse standards for practice* and other relevant standards, codes and guidelines.

Audit of practice

As set out in the *Registration standard: Endorsement for scheduled medicines − designated registered nurse prescriber*, the NMBA may audit your compliance with the registration standard and these guidelines from time to time or if the NMBA receives a notification about you that is relevant to this endorsement.

For sole practitioners or individuals working in private practice the additional requirements outlined above are also subject to audit.