

## Registered nurse and midwife prescribing – Discussion paper

30 October 2017

### Introduction

In Australia, under the Health Practitioner Regulation National Law Act, as in force in each state and territory (the National Law), the Nursing and Midwifery Board of Australia (NMBA) is able to endorse the registration of registered nurses (RN) and midwives as qualified to administer, obtain, possess, prescribe, supply or use scheduled medicines if they meet the requirements of the respective registration standards.

In 2013, the NMBA consulted on a review of the *Registration standard: Endorsement for scheduled medicines for nurses (rural and isolated practice)* (the registration standard). The NMBA proposed to expand the registration standard 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.

In light of the responses to the review consultation, in 2015 the NMBA consulted on a proposal to discontinue the registration standard. However, this proposal was not fully supported as there are two jurisdictions that rely on the registration standard to enable nurses to supply medicines under protocol.

In October 2016, the Health Workforce Principal Committee (HWPC) recommended to the NMBA that the registration standard be continued for two more years to enable the NMBA to work with the two jurisdictions 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.

The NMBA and the ANZCCNMO are working together to facilitate the development of potential future models of prescribing by RNs and midwives. The key focus of any model of prescribing by RNs and midwives is one that promotes safe and improved access to medicines for communities and promotes workforce flexibility. While Australians in general have reasonable access to health care services it is widely acknowledged that there are many people who are underserved because they live in areas or in circumstances where access to health care is restricted, either because of their location, a shortage of health care practitioners or the demands on the health care system. Further, the impact of an ageing population and the increasing level of chronic and complex disease places greater demand on available health services.

Providing equity of access to health care for all consumers requires new ways of delivering that care. One way of addressing the issues associated with access to health care is to expand the scope of practice of health practitioners to provide them with the required skills and competence to provide safe and effective health care and enable them to work to their full scope practice. The expansion of the scope of practice of RNs and midwives in the area of prescribing provides the opportunity to develop innovative models of care that provide safe and effective access to health care for consumers which aligns with the following objectives of the National Registration and Accreditation Scheme :

- to facilitate access to services provided by health practitioners in accordance with the public interest, and
- 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.

The research evidence demonstrates that RNs and midwives who are educated to prescribe within their scope of practice deliver improved access to timely treatment including medications that is cost effective and safe.

Although in Australia we have a federated governance model, there is an opportunity to extend the prescribing rights of RNs and midwives in a consistent manner, including the approaches to education, competence and practice standards in relation to prescribing. A nationally consistent model of RN and midwife prescribing would reduce the risk of confusion, inconsistency and potentially increase the confidence in the safety and effectiveness of health professional prescribing models. As such the NMBA and the ANZCCNMO are committed to the development of a consistent approach to the establishment of models of prescribing by RNs and midwives.

The purpose of this document is to explore potential models of prescribing by RNs and midwives and the framework to support these models. The intention is for any model of prescribing by RNs and midwives to be future focused while recognising and building on the current Australian experience with nurse and midwife prescribing. The key elements of a nationally consistent prescribing framework for RNs and midwives are: education, ongoing competence, practice standards and legislation. Each of these elements will be discussed further in this paper.

## Background

Autonomous prescribing by nurses was introduced in Australia in 2000 with the establishment of the nurse practitioner (NP) role. In 2010, the introduction of the *Registration standard: Endorsement for scheduled medicines for midwives* enabled endorsed midwives to also prescribe autonomously. Prescribing by both NPs and endorsed midwives requires them to meet the requirements of the NMBA including the completion of approved post graduate education, compliance with standards for practice and relevant state and territory legislation and local policies.

Registered nurses who meet the requirements of the NMBA *Registration standard: Endorsement for scheduled medicines for nurses (rural and isolated practice)* are able to supply medicines under protocol in accordance with state and territory poisons legislation.

### International prescribing models

Prescribing by nurses and midwives is well established internationally. Prescribing by NPs was introduced in the United States (US) in the 1960s, and is a role that has been successfully implemented in a number of countries<sup>1</sup>. Prescribing by nurses and midwives in either independent or collaborative prescribing models is legislated in the US, Sweden, United Kingdom (UK), Canada, Ireland, New Zealand (NZ) and Australia.

In the US, prescribing by nurses and midwives has been in place since the 1960s, is regulated at state level, and is limited to legislated advanced practice registered nurses (APRNs) that include NPs, nurse anaesthetists and nurse midwives. 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.

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.

In 2012, the Canadian federal government made changes to regulations under the Controlled Drugs and Substances Act that enabled NPs in Canada to prescribe controlled drugs and substances. Similar to Australia, as a Federated nation aspects of health care are regulated by the provinces and territories in Canada, and thus NPs in some provinces may not be legislatively able to do so.

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<sup>1</sup> Background paper: Registered nurse/midwife prescribing symposium March 2017.

In Canada, midwives may prescribe drugs designated in legislative regulations (i.e. from a formulary). Some medicines may be prescribed independently and other drugs require a physician order for initiation. The regulations also provide for midwives to prescribe any drug that can be lawfully prescribed without a legal prescription.

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

In NZ, nurse prescribing coincided with the development of the NP role in 1999, although initially NP prescribing was limited to a set formulary of drugs. Since legislative changes made in 2014 and enacted in 2016, NPs are now authorised prescribers and can prescribe all medicines within their scope of practice.

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 registered nurse 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. The prescriptive authority of Designated Prescriber: Registered nurse practising in primary health and specialty teams now also incorporates RNs prescribing in diabetes health. These RN prescribers predominately work with people with common, chronic and long term conditions in order to improve 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.

In New Zealand, midwives have been authorised to prescribe since 1990. The education of midwives to prescribe medicines occurs in the four year undergraduate Bachelor of Midwifery program. This education enables midwives to prescribe within their scope of practice and in accordance with relevant legislation. Since July 2014, this prescribing authority includes morphine, fentanyl and pethidine.

These international examples of nurse and midwife models of prescribing provide valuable guidance to inform the future development of prescribing by RNs and midwives in Australia. Many of these models of prescribing were developed to support health reform objectives, improve safe access to medicines for consumers and to improve access to care for consumers. The evidence from evaluation of these models is that nurses and midwives who are educated to prescribe do so safely and effectively within their scope of practice<sup>2345</sup>.

### Australian context

The NP role was established in Australia in the early 2000s, these RNs are prepared at the Masters level and are authorised to prescribe medicines in accordance with the relevant state or territory poisons legislation. In March 2017, there were 1,519 endorsed NPs. The NPs work in a wide range of health care contexts from tertiary hospitals to primary health care contexts and work in collaboration with other health practitioners.

In addition there are 1,125 RNs who have an endorsement for scheduled medicines (rural and isolated practice). This endorsement enables RNs to supply medicines under protocol in rural and isolated health services and is used most commonly in Queensland and Victoria. Protocol prescribing in other jurisdictions is largely covered through local policy arrangements rather than requiring nurses to receive an endorsement by the NMBA.

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<sup>2</sup> Smith A, Latter, S., & Blenkinsopp, A. Safety and quality of nurse independent prescribing: a national study of experiences of education, continuing professional development clinical governance. *Journal of advanced nursing*. 2014;70(11):2506-17.

<sup>3</sup> Pritchard A, & Kendrick, D. Practice nurse and health visitor management of acute minor illness in a general practice. *Journal of Advanced Nursing*. 2001;36(4):556-62.

<sup>4</sup> Hart M. Investigating the progress of community matron prescribing. *Primary Health Care*,. 2013;23(2):26-31.

<sup>5</sup> Fong J, Buckley, T., & Cashin, A. Nurse practitioner prescribing: an international perspective. *Journal of Nursing Research and Reviews*. 2015;5:99-108.

In 2010, the Australian Health Workforce Ministerial Council approved the registration standard endorsement for scheduled medicines for midwives enabling endorsed midwives to prescribe medicines in accordance with the relevant state or territory poisons legislation, there are now 305 midwives who hold this endorsement.

As of 1 November 2010, NPs and midwives with a scheduled medicines endorsement have been able to prescribe medicines subsidised by the Pharmaceutical Benefits Scheme (PBS), Australia's universal subsidisation scheme for specified prescription medicine. Medicines that NPs and endorsed midwives may prescribe independently within the PBS are listed and others are identified as medicines NPs may prescribe for 'continuing therapy only' after the first prescription is made by a medical officer. A number of medicines are also only subsidised if prescribed by a NP within a model of care 'shared' with a medical officer, these are known as 'shared care model' within the Pharmaceutical Benefits Scheme.

On March 21 2017, the Commonwealth Chief Nursing and Midwifery Officer held a Registered Nurse and Midwife Prescribing Symposium. The Symposium provided the opportunity for a diverse cross section of the nursing and midwifery professions and other relevant key stakeholders to consider the future potential for RN and midwife prescribing models in Australia. Participants considered a background paper summarising the current national and international literature on non-medical prescribing and presentations on the day provided participants with an overview of work undertaken previously to underpin the development of the Health Professionals Prescribing Pathway. The participants also explored concepts essential to developing a common understanding of 'prescribing' in the Australian context.

The outcomes of the Symposium identified strong support for enhancing the role the nursing and midwifery professions currently play in the management of medicines by expanding the ability to prescribe. Participants highlighted many ways RN and midwife prescribing would enhance access to medicines for Australian communities and contribute to improved health outcomes, particularly for underserved populations such as rural and remote and indigenous communities.

The report from the Symposium provides a summary of the outcomes that have informed the development of this discussion paper. A link to the report can be found [here](#).

## Discussion

### Rationale for registered nurse and midwife prescribing

- Safe and improved access to medicines for communities
- Promotes workforce flexibility
- Contribute to the delivery of sustainable, responsive and affordable care
- Work to full scope of practice
- Demonstrated to be safe in international settings

### Health Profession Prescribing Pathway

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 medications<sup>6</sup>. A prescriber is defined as a health practitioner authorised to undertake prescribing within the scope of their practice.

In 2013, Health Ministers approved the Health Professions Prescribing Pathway (HPPP)<sup>7</sup>. The HPPP was developed to provide a nationally recognised and consistent approach to prescribing by health professionals. In the HPPP, the four models identified by Nissen et al, (2010) were consolidated into three prescribing models, with differentiation between models related to capability to prescribe medicines autonomously (Model 1) compared to prescribing under supervision of an autonomous prescriber (Model 2) or prescribing via a structured arrangement (Model 3).

The HPPP provides overarching guidance that describes the steps required for a health professional to prescribe and considers principles underpinning prescribing practice, requirements for health professions to prescribe, models of health professional prescribing and roles of stakeholders involved in health professional prescribing.

The HPPP models of prescribing are described as follows:

- 1. Autonomous prescribing:** 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 health care team and ensure appropriate communication occurs between team members and the person taking medicine. This model of prescribing is currently within the scope of practice of NPs and endorsed midwives.
- 2. Prescribing under supervision:** Prescribing 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 a limited authorisation to prescribe medicines that is determined by legislation, requirements of the National Board and policies of the jurisdiction, employer or health service. The prescriber and supervisor recognise their role in their health care team and ensure appropriate communication occurs between team members and the person taking the medicine. This model of prescribing equates with the designated prescribing model for RNs in New Zealand.
- 3. Prescribing via a structured prescribing arrangement:** Prescribing occurs where a prescriber with a limited authorisation to prescribe medicines by legislation, requirements of the National Board and policies of the jurisdiction or health service prescribes medicines 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. This model of prescribing equates with prescribing under protocol and/or standing orders.

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<sup>6</sup> Nissen L, Kyle, G., Stowasser, D., Lum, E., Jones, A., Mclean, C., & Gear, C. Non-Medical Prescribing. An exploration of likely nature of, and contingencies for, developing a nationally consistent approach to prescribing by non-medical health professionals.; 2010.

<sup>7</sup> HWA. Health Professionals Prescribing Pathway (HPPP) Project - Final Report.: Health Workforce Australia; 2013.

## Principles to support expanded registered nurse/midwife prescribing models

A number of underpinning principles have been identified for sustainable RN/midwife prescribing models in Australia to be:

- person-centred – meeting the needs of consumers
- appropriate governance models
- safety and quality in prescribing
- nationally consistent models of prescribing
- relevant to communities, the profession and health systems
- accessible to consumers and addresses service needs, and
- collaboration with other health practitioners.

The development of a RN/midwife prescribing framework must also clearly articulate the role of the prescriber in the [Quality Use of Medicines \(QUM\)](#) as one of the central objectives of Australia's [National Medicines Policy](#).

### Key elements of a nationally consistent framework prescribing by registered nurses and midwives

The following key elements would need to be considered and developed into a framework relevant to the agreed model for prescribing.

#### Regulation and Policy

- Development and establishment of a registration standard for endorsement to prescribe including:
  - Minimum number of years of post registration clinical experience
  - Pre requisite specialist skills and qualifications
  - Requirements for initial and/or ongoing supervision of prescribers.
- Establish minimum prescribing standards to define practice parameters and professional expectations.
- Establish nationally consistent regulatory requirements for continuing competence

#### Education

To support a sound knowledge base from which to prescribe, comprehensive education programs are required to support the safety and success of RN and midwife prescribing. Depending on the model of prescribing that is agreed upon there would need to be:

- a definition of the knowledge, skills, attributes and judgement required to support RNs and midwives to practise safely in the role of prescriber
- a review of the undergraduate RN and midwifery accreditation standards, the Australian Nursing and Midwifery Accreditation Council (ANMAC) has commenced a review of the registered nurse accreditation standards providing a timely opportunity to explore this more closely, and
- development of post graduate accreditation standards to ensure the attainment of competence to prescribe medicines in line with the National Prescribing Service: Competencies required to prescribe medicines.

#### Ongoing competence

To ensure that RNs and midwives prescribers maintain their competence to prescribe, ongoing competence requirements could include:

- a minimum number of CPD hours related to prescribing built into registration standards, and
- a minimum number of practice hours related to prescribing practice.

#### Practice standards

Registered nurse and midwife prescribing – Discussion paper

While the current NMBA *Registered nurse standards for practice* are intended to enable the development of the scopes of practice of RNs, consideration needs to be given to whether the standards require revision to include prescribing practices such as those in the NMBA *Nurse practitioner standards for practice* that include statements about pharmacological interventions.

The requirement for review would also need to be considered for the *Midwife standards for practice* that are currently in development.

#### Options for models for prescribing under a nationally consistent framework

##### **Autonomous prescribing**

The model of autonomous prescribing by NPs and midwives with an endorsement for scheduled medicines is already well established in the Australian context as well as internationally. The evidence suggests that these models of prescribing provide safe and timely access to medicines for consumers. In considering future models of prescribing by RN and midwives, there is the opportunity to explore the expansion of autonomous prescribing beyond NPs and endorsed midwives. The overwhelming support the Prescribing Symposium was that the model of autonomous prescribing should be expanded beyond the scope of NPs and endorsed midwives and apply to RNs and midwives more broadly.

##### *Question 1*

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

*If so, what would be the advantages of expanding this model?*

##### **Prescribing under supervision/designated prescriber (however termed)**

Prescribing under supervision has many similarities to supplementary prescribing in the UK and designated prescribing in NZ. In the UK, supplementary prescribing is within a voluntary partnership between an independent prescriber and a supplementary prescriber to implement an agreed patient-specific clinical management plan with the patient's agreement.

In NZ, designated prescribers may prescribe independently within their scope of practice for patients under their care from a list of medicines specified in their designated prescribing regulations under the sanction of an authorised prescriber and within requirements set by the NCNZ.

Expanding the scope of practice of RNs and midwives to prescribe under supervision or as a designated prescriber (however termed) provides the opportunity for improved safe and timely access to medicines for consumers. This model of prescribing by RNs and midwives has the potential to be utilised in a wide range of health care settings. The intent of the expansion would be to enhance access to medicines for Australian communities and contribute to improved health outcomes, particularly for underserved populations such as rural and remote and indigenous communities.

The development of this model would require the NMBA to develop a scheduled medicines registration standard that established the minimum educational and practice requirements for RNs and midwives to prescribe under supervision.

##### *Question 2*

*Would a model of prescribing under supervision/designated prescribing (however termed) by RNs and midwives provide increased access to health services for consumers?*

##### *Question 3*

- a) *What should the prerequisites, competence, regulatory policy and governance be for prescribing under supervision/ designated prescriber for an RN or midwife?*
- b) *Should there be prerequisites for prescribing under supervision/ designated prescriber and if so what should they be?*

- c) *Should the NPS Competencies limited to relevant elements be the basis of the competence framework? If not what other approach is suggested?*
- d) *What should the regulatory policy be?*
- e) *What would the governance arrangements be to ensure quality use of medicines?*

**Prescribing via a structured prescribing arrangement**

The administration or supply of some medicines under a structured arrangement by RNs and midwives is supported in legislation and/or policy frameworks in some jurisdictions. It is the current view that the preparation of undergraduates in Bachelor of Nursing and Bachelor of Midwifery programs provides the underpinning education to support RNs and midwives to safely administer medications via protocol or standing orders (a structured prescribing arrangement) as a part of normal scope of practice.

The NMBA and ANZCCNMO, supported by the response at the Prescribing Symposium, are of the view that this model of prescribing is adequately governed through relevant jurisdictional policy or legislation without the need for additional regulation by the NMBA through a registration standard or guidelines.

The NMBA and ANZCCNMO will work with the Australian Nursing and Midwifery Accreditation Council to ensure the preparation of both midwife and RN undergraduates to safely administer medications via protocol or standing orders as a part of normal scope of practice is included in all relevant programs.

*Question 4*

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

*Question 5*

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

**Table 1**

**Proposed framework for RN prescribing**

The following table summarises one approach to the framework for RN prescribing:

	<b>Prescribing via a structured prescribing arrangement</b>	<b>Designated prescribing</b>	<b>Nurse practitioner-Autonomous prescriber</b>
Scope of prescribing	Able to identify the need for and supply medicines via approved protocol.	Able to assess and treat a range of conditions in collaboration with an autonomous prescriber.	Able to independently diagnose and treat conditions within their scope of practice.  Collaborates with other health practitioners as required.
Education and experience	Included as a part of the undergraduate registered nurse curriculum.	Post graduate qualifications in prescribing, including pathophysiology, assessment and based on the NPS prescribing competencies and QUM.  Minimum three years post graduate experience as a	Nurse Practitioner Masters degree.  Post graduate experience of 5,000 hours in advanced practice.

		registered nurse.	
Prescribing authority	Limited to agreed medicines as per approved protocol.	In accordance with jurisdictional regulations and/or policy frameworks and guidelines.	Authorised prescriber in accordance with state and territory poisons legislation.
Regulation	State and territory legislation and local policies.	Endorsement by the NMBA.  State and territory legislation and local policies.	Endorsement by the NMBA.  State and territory legislation and local policies.

### Question 6

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

While this paper has been inclusive of both RNs and midwives it is recognised that the current framework for midwife prescribing involves endorsement and a limited range of medicines relevant to midwifery context of practice that can be prescribed. There is the potential for the framework described above to be extended to cover midwives as well or for a separate approach to be taken. It is suggested that consistency between the frameworks would support ease of administration and understanding by both consumers and prescribers while still enabling midwives in their practice. It would also be consistent with the HPPP, QUM and NPS competency frameworks.

### Table 2

#### Proposed framework for midwife prescribing

The following table summarises one approach to the framework for midwife prescribing:

	<b>Prescribing via a structured prescribing arrangement</b>	<b>Designated prescribing</b>	<b>Midwife with scheduled medicines endorsement- Autonomous prescriber</b>
Scope of prescribing	Able to identify the need for and supply medicines via approved protocol.	Able to assess and treat maternity associated conditions in collaboration with an autonomous prescriber.	Able to independently diagnose and treat maternity related conditions within their scope of practice.  Collaborates with other health practitioners as required.
Education and experience	Included as a part of the undergraduate midwifery curriculum.	.	Post graduate diploma in prescribing, including pathophysiology, assessment and based on the NPS prescribing competencies and QUM.  Minimum three years

			post graduate experience as a midwife.
Prescribing authority	Limited to agreed medicines as per approved protocol.	In accordance with jurisdictional regulations and/or policy frameworks and guidelines.	Authorised prescriber in accordance with state and territory poisons legislation.
Regulation	State and territory legislation and local policies.	Endorsement by the NMBA.  State and territory legislation and local policies.	Endorsement by the NMBA.  State and territory legislation and local policies.

*Question 7*

*Should the framework described in Table 2 apply to midwives?*

*If not what alternative approach is suggested?*