New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

26 January 2021

Ministry of Health
Wellington

By email: chiefnurse@health.govt.nz

Proposed amendments to the list of specified prescription medicines for designated registered nurse prescribers

Dear Sir / Madam

The New Zealand Medical Association (NZMA) wishes to provide feedback on the above consultation. The NZMA is New Zealand's largest medical organisation, with about 5,000 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. Our submission has been informed by feedback from our Board, Advisory Councils and members.

We note that the Nursing Council has recommended the addition of 60 prescription-only medicines it considers appropriate for designated registered nurse prescribers in primary health and specialty teams. We understand that the existing list of prescription medicines for designated registered nurse prescribers was developed in 2014 and came into effect in September 2016.[1] We are aware that registered nurses who wish to prescribe are required to have additional qualifications including the completion of a Council-approved postgraduate diploma in registered nurse prescribing and a practicum with an authorised prescriber.

We have a number of concerns with the proposed amendments to the list of specified prescriptions. These concerns include the observation that several medicines on the list are highly specialty specific and require specialised prescribing beyond the standard training that registered nurse prescribers are required to undertake. While some of the medicines may be appropriate for nurse prescribers who have experience in specialty teams, we are concerned that all the medicines on the list would be available to all nurse prescribers, including those working in primary care. While there is a requirement for ophthalmology medicines on the existing list that "these medicines may only be prescribed by registered nurses authorised to prescribe who are employed in a collaborative ophthalmology specialist team", no such restrictions apply for other medicines on either the existing list or any medicines on the proposed amended list for other specialty areas such as cardiology.

While a number of these proposed medicines are only able to be prescribed as "continuation prescribing", this in itself entails considerable responsibility and consideration of factors such as new medicines started and changes in renal function. It would be misguided to assume that

[1] https://www.nursingcouncil.org.nz/Public/Nursing/Nurse_prescribing/NCNZ/nursing-section/Nurse_Prescribing.aspx?hkey=091ed930-56ca-4f25-ae9e-52b33decb227

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continuation prescribing is an easy no-issues option that somehow rationalises access to a large number of specialised medicines. We are also concerned at the inclusion of unfunded medicines (eg, rosuvastatin) and note that the classification of sacubitril for hypertension is incorrect. We seek clarification on whether the absence of any restrictions for prescribing dabigatran or rosuvastatin mean that registered nurse prescribers can initiate prescribing of these medicines without restrictions.

While registered nurse prescribers are required to be part of a collaborative team so that they can consult a doctor or nurse practitioner "if the patient's health concerns are more complex than the nurse prescriber can manage", our view is that many of the drugs on the proposed list should not be prescribed by a nurse prescriber without consultation with an authorised prescriber that has appropriate specialised training.

We also wish to make the following suggestions and observations:

- We feel that further specific training is necessary before registered nurse prescribing rights are given for anticoagulants.
- Third line and onwards medications for diabetes management should require input from a GP / nurse specialist / secondary care, and potentially be restricted to continuation prescribing.
- Inhaled tobramycin should only be able to be prescribed as continuation or require consultation regarding antibiotic stewardship.
- Tamoxifen seems an odd addition to the list, especially for first-time prescribing.
- Very few of the medicines on the list would be appropriate for the paediatric population without appropriate consultation.

We seek further information from the Ministry about the process by which registered nurse prescribing of these proposed new medicines (and indeed of existing medicines on the list) is monitored and audited. It is important to identify areas where problems may be occurring and address these as part of continuous quality improvement. To help with the review and monitoring of registered nurse prescribing, authorised prescribers working in relevant specialty areas should have clear mechanisms and pathways to be able to raise concerns with such prescribing where they arise.

Our view remains that the prescribing of medicines is not a discrete activity but rather a tool in the practice of medicine and the overall care of the patient. Prescribing cannot be considered in isolation from diagnosis and/or monitoring of disease progression. These require knowledge and skills built on years of study of anatomy, pathology and physiology, accompanied by training in clinical methods. For this reason, we have previously called for nonmedical prescribing to take place under a delegated model of prescribing that we believe would mitigate the risks involved in non-medical prescribing while achieving the collaborative team based care that is the shared objective of the medical and non-medical healthcare professions. This continues to be our position although we understand that a new Therapeutic Products Act may disestablish existing categories of prescribers.

We hope our feedback is helpful.

Yours sincerely

Dr Kate Baddock
NZMA Chair