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## **More hurdles for nurse prescribing?**

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Comment

The drive to create a flexible and responsive health workforce is an area of pressing concern to all who work in health.

Many will be aware of the recent proposal by Health Workforce New Zealand (HWNZ) to initiate nurse prescribing in diabetes services. Under this proposal nurses working as diabetes nurse specialists will be approved by the Nursing Council as designated prescribers in three trial demonstration sites yet to be set up. The plan will be evaluated in September 2011.<sup>1</sup>

There are now several thousand registered nurses who already have the post-graduate education and practice experience to prescribe, but have not applied to the Nursing Council to be registered as a nurse practitioner (NP).

Legally, NPs are designated prescribers and able to prescribe independently within their defined area of practice. The postgraduate clinical master's degree completed by these nurses and NPs includes (among other things) pathophysiology, advanced health assessment clinical pharmacology and a prescribing practicum supervised by an existing prescriber, such as a general or NP or medical consultant in the relevant specialty.

There are a range of reasons why these expert nurses who have a clinical master's degree have not applied to the Nursing Council; there is a dearth of employment opportunities despite the clear need for a NP service, as well as the rigour of the council application process. The opportunity arising from the HWNZ proposal for diabetes nurse specialists, therefore, has its attractions.

Few would argue about the inconvenience of the countersigning requirements in the Standing Orders Regulations 2002 by which nurses and the issuer of the order must abide. Indeed, it is the constraints of the standing orders that led to the HWNZ proposal for diabetes nurse specialists.<sup>2</sup>

There is also unequivocal evidence safe and timely access to medicines in general improves health outcomes and reduces hospital admissions.<sup>3,4</sup>

The most impressive gains have been made in the UK since 2005 with a clear government policy to support the extension of prescribing responsibilities to non-medical professionals.

There are now over 16,000 registered nurses who can independently prescribe any medicine for any medical condition within their competence on the same basis as doctors. These nurses complete a

degree level course comprising 26 theory days and 12 days of supervised prescribing practice.

On the basis of these gains in the UK - remembering New Zealand education significantly exceeds that of the UK - it is hard to understand why there would be such poor use of the investment made by our Government in postgraduate nursing education (via the Clinical Training Agency - now HWNZ).

There is potential to enhance the practice of this growing group of under-utilised master's-prepared nurses, as well as meet the health goals of all sectors of New Zealand's population now, not only those with diabetes.

Where the HWNZ proposal for diabetes nurse specialists loses its appeal is the underlying suggestion that, if this trial is not successful, demonstration sites will not be rolled out for other groups. Success would bring the promise of an incremental rollout, but could take many years, with each new phase likely to be dependent on the success of the previous one. I am not sure we can afford to take this long.

Referred to as a workforce innovation in the discussion document, the current HWNZ proposal could be considered a retrograde step in the journey towards improving access to medicines. It has remarkable similarities with the New Prescribers Advisory Committee (NPAC) established over 10 years ago following the Medicines Amendment Act 1999 for new groups of health professionals seeking prescribing rights.

Under the regulations associated with the amendment, nurses practising in aged care and child family health could prescribe from a limited schedule of medicines. Only one nurse ever prescribed under these regulations and, in her experience, the schedule rapidly became out of date and impeded best practice.

The latest HWNZ proposal, however, would introduce additional hurdles for new groups of specialist nurses seeking prescribing rights that were not required by NPAC, by demanding demonstration sites be set up, as well as an evaluation, then consultation with stakeholders.

In the interests of pressing consumer need for timely and appropriate access to medicines, a more sensible solution to unlocking the potential of such a well-educated workforce is to simply amend the regulations to make provision for nurses with the appropriate clinical master's degree to be regulated by the Nursing Council as designated prescribers in their named area of specialty.

Stipulating a specific area of expertise imposes a limitation on practice so that a nurse who nominates the specialty area of, for example, "wound care" may prescribe only in relation to wound care, and clearly not, for example, a cardiac-related condition. The very nature of long-term conditions and the inevitable presence of comorbidities clearly demands a more comprehensive service.

The Government has wisely invested in postgraduate nursing education and could readily realise the investment by properly matching the regulatory environment to the skillset of an existing workforce. It

seems, however, that we must assent to the current proposal if nurse prescribing is to progress at all.

Lessons from the past and from the UK experience could be drawn upon to better utilise the existing well-educated nursing workforce. Far from straightforward, the process for getting NP prescribing into law has been a frustrating journey. The journey ahead towards autonomous positioning of registered nurse prescribing without oppressive restrictions is set to be similar.

### **References**

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3. Bradley E, Hynam B, Nolan P. Nurse prescribing: Reflections on safety in practice. *Soc Sci Med* 2007;65(3):599-609.
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