

Decision regulation impact statement

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

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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 by working to their full scope of practice.

The reform is driven by the Australian government's commitment 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 and health service.

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

An objective of the *National Medicines Policy* (2022) is that all Australian communities receive equitable and timely access to healthcare including medicines. The policy aims to ensure the provision of timely, safe and affordable access to a high-quality and reliable supply of medicines and medicines-related services for all Australians. This should include support for a positive and sustainable policy and the successful development of medicines and medicines-related services in Australia that focus on person centred care and informed choice. ²

The Australian Government's *Stronger Rural Health Strategy*, *Strengthening Medicare Taskforce Report* and the *Future focused primary health care 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. ^{3,4,5} As part of the strategies, strengthening the role of the nursing workforce is critical to delivering increasing interprofessional practice and nursing-based models of primary healthcare across rural and remote communities. Allowing nurses to work to their full scope of practice can expand access to care, improve case management and care coordination, reduce the need for hospitalisations and emergency department use and improve patient care results.

These objectives align with the National Accreditation and Registration Scheme (the National Scheme) which aims to facilitate workforce mobility across Australia, enabling the evidence-based development of a flexible, responsive and sustainable Australian health workforce. ⁶

Investing in advanced models of care for the nursing workforce contributes to healthcare system effectiveness by recruiting and retaining nurses across various health contexts. It also delivers improved collaborative practices that extend beyond 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 evolve are continually opening up. 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 to ensure 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 and successful health system responses for the future that are resilient against public healthcare emergencies.

Investment in the development of advanced roles for nurses would help alleviate the strain on the health system created as a by-product of the COVID-19 pandemic and ongoing population health issues. 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. The growth in life expectancy will likely increase the burden of disease and the associated chronic complex comorbidities that place even the most comprehensive health systems under strain. ⁷

RNs are integral to 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. Enabling RNs to prescribe scheduled medicines could allow them to respond to the growing demands in health and population needs and enhance healthcare system efficiency.

There are a range of areas where RNs can expand 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 safely prescribe medicines in a supervised and collaborative 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 (2023)* report found that employing 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. ⁸

The NMBA and the ANZCCNMO have developed options for RN prescribing models to align with the key healthcare strategies of the Australian Government. Implementing designated RN prescribing for appropriately trained and supported nurses to prescribe within and to 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 healthcare services. These models also have the potential to alleviate the pressure points across acute and primary care and where access to general practitioner appointments, particularly in areas experiencing workforce shortages is problematic for healthcare consumers. Models of RN prescribing, particularly across the acute and primary care setting, are likely to facilitate flexible service delivery to meet healthcare consumer needs.

The issues Paper 1 as part of Phase 2 of the *Unleashing the Potential of our Health Workforce – Scope of Practice Independent Review*, released 23 January 2024, provides strong evidence from the literature review and advocates that when health care professionals are able to work to full scope of practice, consumer access to healthcare, healthcare experiences and health outcomes are improved. Additionally, this creates health care system efficiencies through decreased pressure on the acute care sector, improved role utilisation and increased retention of health professionals. ⁹ This decision regulation impact statement (D-RIS) evaluates the potential impacts of 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).

The D-RIS is informed by extensive consultation undertaken with both health professions and the public. It describes the objectives and evaluates the options proposed based on feedback to the C-RIS. The preferred option is to enable RNs to prescribe scheduled 2,3,4 and 8 medicines under supervision, in accordance with governance frameworks and prescribing agreements. The D-RIS outlines the regulatory impacts (risks, costs and benefits) of the proposed registration standard to better inform the regulatory, social, economic and health impact outcomes as a result of the prospective change.

It should be noted that nurse practitioner (NP) prescribing is out of scope for this D-RIS, as NPs already have authority to autonomously prescribe within their scope of practice. It is also important to note that the NMBA and Ahpra do not have responsibility for developing health system requirements such as clinical governance structures within healthcare organisations or developing and integrating endorsed designated RN prescribers into health funding systems such as the Pharmaceutical Benefits Scheme (PBS) and Medical Benefits Schedule (MBS).

Background

The role of the NMBA and the National Law

The NMBA is one of 15 National Boards in the National Scheme. The National Scheme is governed by the Health Practitioner Regulation National Law (the National Law) as in force in each state and territory. The NMBA regulates the practice of nursing and midwifery in Australia, and one of its key roles is to protect the public and maintaining public confidence in the safety of health services. The NMBA does this by developing registration standards, professional codes, guidelines and standards for practice which together establish the requirements for the professional and safe practice of nurses and midwives in Australia.

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 and maintain public confidence in the safety of health 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.

In building the capacity of the Australian health workforce, the National Scheme supports the governments' commitment to embed cultural safety and eliminate racism in the health system in the provision of culturally safe health services to Aboriginal and Torres Strait Islander Peoples. Under section 38 of the National Law, a National Board can develop registration standards. 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 developed options and a preferred option for potential models of RN prescribing.

The role of registered nurses in primary care

Exploring the role of the RN in the healthcare system, a review of the literature around RN prescribing globally provides an important illustration of the need for this approach to reform.

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 Australia there were 7.6 general practice (GP) attendances per person in 2020-2021 compared to the 6.3 per person in 2018-2019.¹⁰

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 including GPs, 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 and the demand for primary healthcare services continue to rise. This is highlighted by:

- 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 2018–19.¹⁰
- 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 2019–20.¹⁰
- 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 2019–20.¹⁰

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.¹¹

The role of registered nurses in our healthcare system

Of the 833,318 registered health practitioners in Australia, almost half (47%) are RNs (408,469). Of this number 62,591 work outside of metropolitan and regional centres – in rural, remote or very remote communities.¹²

RNs are comprehensively educated and have a broad scope of practice. They work as a part of interprofessional 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 responsibilities 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, nurses 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 legislative authority for RNs to administer scheduled medicines is determined by or under legislation of the state or territory.

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 through its regulation and response.¹³

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.^{14,15}

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 classifying

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which medicines or poisons need to be more tightly controlled, and which don't. In Australia, there are schedules that are arranged from least to most tightly controlled.¹⁰

Medicines are classified under schedules 2, 3, 4 and 8 with examples described in the table below.

Table 1: Description of scheduled medicines relevant to designated RN prescribing

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:^{16,17}

- 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 of \$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 expends a lot of time, money and human resources. GPs are having to prescribe the bulk of medicines the Australian community, primarily to manage long term chronic conditions. This trend is concerning as the *General Practice: Health of the Nation* (2022) report raised 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.¹⁸

The medication management cycle

The medication management cycle (MMC) describes the key steps and background processes that underpin medicine use in all settings for quality use of medicines and medicine safety. The MMC provides

a framework for understanding and improving medication management in episodes of care where medicines are involved.^{19,20}

The cycle comprises the following steps:

- The decision to prescribe if a medicine is required
- Recording the medicine or prescription
- Reviewing the medicine or prescription
- Issuing the medicine which includes dispensing and supply
- Providing medicines information to the patient/client in how to store and use the medicine
- Appropriately distributing and storing the medicine
- Administering the medicine
- Monitoring the patient/client response to medicines
- With the patient's/clients consent transferring information about the medicine to health care professional involved in the next episode of care.

Nurses already play a crucial role in the medication management cycle. In rural and remote areas where nurse led services are prevalent, RNs are already shouldering responsibility for the MMC.²⁰ RNs work across all sectors of healthcare and are well placed from a workforce distribution perspective to improve access and equity in healthcare. With further education and training, RNs can extend their involvement in the medication management cycle to include prescribing.

The 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 practice.²¹

In 2013, Health Ministers approved the Health Professionals Prescribing Pathway (HPPP) project. 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 details various models of prescribing. Three models of prescribing were identified by the HPPP, each based on the level of autonomy afforded to the relevant health professional undertaking the prescribing duties.²¹

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 the Ministerial Council is compliant with the HPPP which ensures consistency across the profession, in the setting of course curricula and qualification requirements for clinical practice standards and guidelines that support the quality use of scheduled medicines.

The HPPP project established the models of prescribing for health practitioners in Australia. The NMBA has developed the options in this paper in relation to the HPPP.²¹

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 Decision regulation impact statement: Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber

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.

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 of June 2023, there were 2,494 NPs or 0.7% of the overall RN workforce.²²

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 of 1 February 2023, 1,275 RNs (0.3% of the total RN workforce) with an endorsement for scheduled medicines 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.²² This endorsement was retired in 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.

In summary, dependent on jurisdiction and employing organisation, RNs that are not qualified as NPs may prescribe via structured prescribing arrangements.²⁰ There are two common types of prescribing arrangements – ‘prescribe to administer’ where an RN is authorised only to administer a single dose of a medicine, and ‘prescribe for supply’ where an RN is authorised to prescribe a medicine for a short or ongoing course of therapy. In this structure there is no consistent approach or existing operationalised standards for RNs who work with and under these arrangements to ensure that they are competent or educationally prepared to perform these tasks.²⁰

Midwifery prescribing models

Midwives in Australia who have undertaken additional postgraduate training and hold additional prescribing qualifications can also prescribe medicines within their scope of practice with an endorsement. The endorsement means that the midwife has met the requirements of the NMBA Registration standard: Endorsement for scheduled medicines for midwives and is qualified to prescribe scheduled medicines 2, 3,4 and 8. This standard came into effect in January 2016 and is similar to the model proposed for designated prescribing apart from the varying clinical context. There are 1,089 endorsed Midwives as of 30 June 2023.

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 examples of nurse prescribing models provide valuable guidance to inform the development of designated RN prescribing 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 RNs 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 postgraduate diploma level.²³

In the UK, various forms of nurse 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.²⁴

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.²⁵

In 2011, New Zealand 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. RNs practising in primary health and specialty teams now also incorporate RN prescribers in the area of diabetes health. These RN prescribers predominantly 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.²⁶

International reviews of the literature related to RN prescribing

In 2018, an exploratory literature review of prescribing by nurses and midwives identified that RN prescribing has dual benefits for patients as well as the nursing profession. Survey responses 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.²⁷

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.²⁸

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 cases. Out of 15 patients treated by an RN prescriber, 13 participants (86%) felt that their relationship with the RN was enhanced as a result of the RN's ability to prescribe.^{27,28}

Several studies that reported a high proportion of patients who have experienced RN prescribing had no preference in relation to who they may see regarding future treatment between an RN or other medical practitioner. These findings suggest that many patients are comfortable with 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.²⁴

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 a 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.²⁵

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.^{27,29}

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 (17.5 to 14.5 days).³⁰ In another study, the length of stay was reduced by two days in the RN prescribing intervention group (nine to seven 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 (six to four) and an overall mean reduction of 21 errors.^{30,31}

In another study, an evaluation of 32 community patients in the palliative care setting was undertaken to determine the time taken for patients to receive medication prescribed pre and post implementation of RN prescribing. 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, 50% of patients in the palliative care setting received medication within 5 hours and 86% in less than 24 hours which marked a significant improvement.^{32,33}

In a study of RN prescribers, a total of 776 (89%) out of the 886 sample 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.²⁹

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 and the public who had experienced RN prescribing also felt confident. 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 prescribed.^{34,35,36,37}

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.²⁰

1. What is the problem we are trying to solve?

Government policy reports dating back to 2005 including a Productivity Commission report state that there is an opportunity for RNs to extend their scope of practice and prevent some of the unhealthy outcomes associated with less than optimal use of medicine. The report included using a collaborative health professional approach that has the potential to increase the scale and effectiveness of access to healthcare by addressing the barriers and the problems outlined in this D-RIS which continue to impede access to medicines.³⁸ The National Health Workforce Planning and Research Collaboration in 2010 also stated that the number of Australian prescribers needed to increase to maintain access to medicines.³⁹

Australian healthcare consumers do not have equitable and timely access to medicines or medicines related services. Equitable access to healthcare must be at the centre of health reform. There are multifaceted problems that result in difficulties with access to medicines, which adversely affect health consumers symptom control related to diagnosis, experiences of healthcare, health outcomes and quality of life for consumers.⁴⁰

Problem 1: Inequities across healthcare in rural, regional and remote communities

Patients in regional and remote communities face challenging living situations and rural Australians do not have equitable health outcomes.⁴¹ 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. Additionally smaller rural towns have the lowest number of health professionals per capita. Patients living in rural communities are having to expend considerable time and effort to access health services. They are driving long distances and experiencing long wait times to get their basic healthcare needs met. This creates increased pressure on regional and metropolitan health hubs leading to an increase in emergency department presentations.⁴¹ There is a higher burden of disease in rural Australia with patients living with long term health conditions such as arthritis, asthma, back problems, diabetes, heart and vascular disease. This can add further considerable stress on the healthcare system. Due to their 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 as they may only seek care if their health conditions become severe.^{42,43} There is a higher burden of disease in rural Australia and this represents a \$27.5b loss in economic contribution and also supports an overrepresentation of potentially avoidable deaths and decreased life expectancy.⁴¹

Problem 2: Cultural and social inequities in healthcare

Cultural and social backgrounds and geographical location should not be barriers to achieving timely access to healthcare. Aboriginal and Torres Strait Islander Peoples experience higher levels of unsatisfactory health outcomes with burden of disease 2.3 times that of non-Indigenous Australians.⁴⁴ The leading contributors to disease burden were mental health and substance use, followed by chronic health disease such as cardiovascular, respiratory, kidney, musculoskeletal disease, cancer and sexually transmissible infections. The Aboriginal and Torres Strait Islander population increases with geographical remoteness and as such these communities often have lower access to health services.⁴⁵ Despite significant efforts by the Australian government, scholars, policy makers and communities to provide fair and equitable healthcare, this challenging and longstanding issue remains unresolved and does not aid in meeting the Governments National Agreement on Closing the Gap and to overcome the inequality experienced by Aboriginal and Torres Strait Islander people and in achieving life outcomes equal to all Australians.⁴⁶

Problem 3: An ageing population and the impacts for healthcare

There is an ageing global population. The World Health Organisation (WHO) predicts that by 2050, there will be 1.5 billion people over 65 years of age. On 28 June 2023, the Australian Institute of Health and Welfare's publication *Australia's Health* estimated that 16% of Australia's 26 million people are currently over the age of 65, that percentage is projected to increase to 23% by 2061. Five per cent of the population is projected to be over the age of 85 by 2061.⁴⁷

This has implications for healthcare as with increasing life expectancy is the increased burden of chronic disease. The diabetes epidemic is currently one of largest and most complex challenges in healthcare, with 1.5 million Australians living with diabetes. In 2021-2022 there were 1.3 million hospitalisations associated with diabetes with most hospitalisations (72%) occurring in those aged over 60 years. Complications associated with diabetes include the risk of dementia, cardiovascular disease, stroke, end

stage kidney disease, and blindness. This places enormous pressure on already stretched health services and workforce. ⁴⁸

As of June 2022, approximately 407,000 people were using residential aged care, home care or transition care in Australia. Forty-six per cent of those people were using permanent or respite residential aged care. ⁴⁹ The number of people entering and living permanently in aged care increased by 3.1% over the past five years, which can be attributed to the Australia's ageing population. ⁴⁹ With an ageing population comes the need for increases in care requirements as aged care residents experience multiple comorbidities in their health. The final report of the Royal Commission into Aged Care Quality and Safety (2021) identified that adequate qualified staffing levels are critical to the quality of residential care, and recommended at least one RN be on-site at all times at each residential facility. ⁵⁰

This will ensure that aged care residents have access to high quality clinical care at all times. This care could include medication management which would assist in care decisions around responding to aged care residents' condition and helping to prevent unnecessary hospitalisations through medication management and access to high quality palliative care.

This aligns with the Aged Care Royal Commission recommendations as traditionally there has been a lack of support in the aged care sector to deliver quality palliative care. These barriers impact experiences of death and dying of the resident in aged care, their families and aged care staff and leads to increased costs to the health sector due to avoidable and unnecessary hospitalisation of residents.

There is also increasing demand for acute care services across the spectrum in both hospital and community settings. It has been reported that even countries that currently have comprehensive healthcare systems are likely to experience service gaps in the future, which may cause disparities in healthcare outcomes. ³³ Internationally, many countries have already adopted innovative models of RN prescribing and policy makers, governments and health departments in Australia should consider similar models to effectively address and meet the ongoing health service 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. ⁵¹

These included:

- developing 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
- working with states and territories to review barriers and incentives for all health professionals to work to their full scope of practice
- a need to break down barriers 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.

Problem 4: The impacts of COVID-19 on the utilisation and access to healthcare services

The COVID-19 pandemic exacerbated inequities in healthcare for consumers. Access to healthcare was further limited due to lockdowns and border closures causing workforce shortages in key areas. Wider impacts have been to the health of the Australian community. The inability for many Australians to access timely care due to the prolonged lockdowns has led to a backlog in people accessing care for management of diagnosed illness and treatment of health issues, or subsequent new diagnosis in which there has been treatment and management delay.

Whilst emergency departments had a steady flow of patient presentations during the COVID-19 pandemic, restrictions led to a decrease in elective surgery by 8.3% in public hospitals and 5.7% across private hospitals. The restrictions and delays to elective surgeries have resulted in an increase in waiting times for patients waiting for elective surgery from 2.8% to 7.6%. A proportion of these patients now have a wait time of more than 365 days for their elective surgery. ⁵² An example is the wait time for a total knee replacement which has increased from 11-32% aligning with a projected burden of disease of 236% by 2030. Many of these patients will continue to present to GPs for ongoing symptom management during their waiting period for non-operative management and a stepwise approach to analgesia or pain relief which is recommended and required for patients in order to maintain their normal activities of daily living. ⁵³

During the COVID-19 pandemic, delays to screening examinations such as breast, cervical and colonoscopy as well as postponed and/or cancelled patient appointments resulted in a 40% decrease in new cancer diagnoses. This has subsequently resulted in patients now being diagnosed at more advanced stages of the disease process.⁵⁴

There is also accumulating strong evidence that COVID-19 can result in long term organ damage which predisposes patients to new chronic conditions in the post-acute phase now termed long COVID. This should be cause for concern as chronic conditions are already the leading cause of death in Australia. The impacts of long COVID on respiratory, cardiovascular, kidney disease and diabetes are continually being recognised.⁵⁴ The prevalence of increasing mental health and neurological disease post COVID and in long COVID patients has also been reported on. Health policies will need to be cognisant and considerate to make sure strategies do not further exacerbate inequities in access to medicines and healthcare in Australia. There is limited data in Australia on long COVID prevalence, however it is estimated that it affects 5-10% of COVID-19 cases leading to an increase the burden of non-communicable disease in Australia.⁵⁴

There have been some studies undertaken that have demonstrated a correlation between diagnosis of COVID-19 and increased post-acute care activity within healthcare settings. An English study in 2022 revealed that there were statistically significant increases in non-elective admissions for patients aged below 65 years who were hospitalised during an acute COVID-19 infection. For the COVID-19 positive cases that were not hospitalised, there were significant increases across all ages in attendances to GPs (including prescriptions) and nurses, emergency department presentations, outpatient consultations and mental health contacts. This was also reflected in a study undertaken in Italy and in the United States.^{55,56}

COVID-19 has placed unprecedented demands on the health workforce including ongoing challenges to supply and distribution of health professionals.

Problem 5: Preventable hospitalisations

Potentially preventable hospitalisations (PPH) also known as preventable hospitalisations are those admissions to a hospital that could have been potentially prevented through timely, accessible, and appropriate healthcare management and intervention. This care can be delivered in primary and community settings by GPs, NPs and allied health professionals.^{57,58}

Designated RN prescribers could play a significant role in preventing health deterioration and PPH through improved access, efficiency and patient convenience.⁵⁹ During 2021 in Queensland, there were 167,675 PPHs. Adults aged 85 and older experienced the highest rate which also varied by remoteness and socioeconomic status. More than 87% of those living in socioeconomically disadvantaged areas were likely to experience PPH and those living rural and remote areas twice as likely to experience PPH in comparison to those living in major cities. Diabetes or diabetes associated conditions were one of the largest causes of PPH.⁶⁰

From 2019-2021, 15% (92,019) of hospitalisations for Aboriginal and Torres Strait Islander people were potentially preventable. This is a rate of 55 potentially preventable hospitalisations per 1,000 population.⁽⁴⁰⁾ The *National Healthcare Agreement* affirms that Australia's health system should maintain health, support an integrated approach to treatment across the lifespan and provide timely access to quality health services for all Australians regardless of where they live.⁶¹ Models of care using expanded scopes of practice to manage acute and chronic conditions within the community may lead to lower rates of hospitalisation and length of stay.

Individuals affected by the problem of RNs not being able to prescribe

The below journeys are real-life scenarios provided by RNs working in health services in follow-up discussions to the consultation questions within the C-RIS. The RNs communicated these scenarios to demonstrate the limitations in their current scope of practice, and to express the frustration they felt as these limitations impacted not only the timeliness of care but also the overall quality of care and outcomes for the patients, residents and their families. If appropriately trained and educated, RNs could prescribe within their scope of practice under the supervision of an authorised prescriber with a prescriber agreement in place, judiciously, appropriately and safely after having undertaken further education to demonstrate competent prescribing,²⁰ these patients' experiences could have been different. The patients and their families could have experienced less stressful, more co-ordinated episodes of care throughout

their individual healthcare journeys and perhaps a more comfortable and dignified death if a holistic approach to care was applied through RN's expanded scope of practice.

Charlie's journey

Charlie, a 73-year-old patient with end stage liver failure and encephalopathy, was being cared for in his home by the community palliative care nurse consultant when his condition quickly deteriorated. At the time, no palliative care medications were in place and discussions with his family regarding after hours medication had not occurred. Charlie became terminally agitated and distressed which caused immense distress to his family. The community palliative care nurse consultant was limited within her scope to provide treatment within the home and Charlie was transferred to hospital via ambulance and admitted to the emergency department. Charlie died in the emergency department after lying on a trolley for four hours. Charlie had not wanted to be hospitalised if he deteriorated, however his family were too distressed by his discomfort and the community palliative nurse consultant was not able to assist with care within his home.

Tahlia's journey

Tahlia, a 24-year-old, well known to the community mental health team had run out of her regular medication over a weekend. As a result, her distress and anxiety levels increased leading Talia to call an ambulance. An RN working interprofessionally with the ambulance service who knew Talia also attended the call with the ambulance staff. The RN was able to access Tahlia's electronic medical health record (EMR) to further establish a history and could see the order of regular anti-depressant and anticonvulsant medicines prescribed to treat Tahlia's epilepsy and schizophrenia. A GP was contacted to write a prescription however refused to provide a bridging order. Tahlia was subsequently transported to the nearest emergency department and triaged where a prescription was written by a mental health NP. This process was incredibly distressing to the Tahlia causing a 6–8-hour intervention.

Kirra's journey

26-year-old Kirra was experiencing nausea secondary to pregnancy. Kirra had a history of anxiety and depression and had recently commenced on low-risk antidepressants to manage her increasing anxiety around her pregnancy and social circumstances. The commencement of the medicine caused an increase in nausea which in turn increased the anxiety being experienced by Kirra. Kirra required review, assessment, some supportive strategies as well as anti-nausea medicine which required a prescription. Kirra was unable to get an appointment with her regular GP however a new clinic was taking appointments for the following day, but the consultation cost was \$100 which was out of Kirra's budget. This left Kirra with no other alternative but to present to the emergency department despite her anxiety about attending hospital. Kirra spent five hours in the emergency waiting area during which she was only provided with a vomit bag for her nausea. On admission to an emergency bay a single dose of anti-nausea medicine was written up by the doctor and administered by an RN. Kirra was advised to re-present to the emergency department again if required.

Paul's journey

Paul, a 51-year-old living in regional Australia takes clozapine for his schizophrenia. During a home visit by the community mental health RN, a change in Paul's behaviour was noticed. Paul was well known to the community health team and the RN could readily access Paul's up-to-date blood profiles and assessments relevant to his clozapine treatment. Paul advised the RN that he had not taken his clozapine for four days or more. Paul's regular GP was on leave and could not be contacted and the community mental health RN advised Paul to present to the nearest emergency department to further assess Paul's increasing breakthrough symptoms. Paul did not present to the emergency department. He was eventually admitted to the intensive care unit (ICU) via the emergency department and ambulance after drinking gastric eroding household cleaner and spent two weeks in the inpatient mental health unit post discharge from ICU.

Molly's journey

Molly was living with cerebral palsy and schizophrenia and had become fixated on her pregnancy diagnosis. Molly had good insight into her illness and management and knew that she was verging on a psychotic episode. The episode occurred on a weekend in a rural area. The community mental health RN was able to access Molly's electronic medical health records (EMR) and was able to see that previously in similar circumstances Molly had been prescribed and administered an antipsychotic medicine, risperidone

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until further review. The local community setting did not have facilities for a cerebral palsy patient and there were no beds. Molly commented that hospital admissions were disempowering. In this instance to avoid hospitalisation at Molly's wishes, the community mental health RN was able to involve her family to provide interim care and prevent the need for hospitalisation. Molly had a two-day wait to see the local GP who then prescribed risperidone.

Broadie's Journey

Broadie, a 21-year-old apprentice carpenter sustained a small laceration at work which he did not believe required any further treatment apart from initial first aid on site. A few days later Broadie's arm became red and inflamed. He was unable to get a GP appointment however presented at a clinic near his house. On assessment the RN at the clinic made an initial unsupported diagnosis of cellulitis and advised Broadie that he would need to see a doctor for antibiotics. Broadie was unable to get an immediate GP appointment. Broadie's arm became progressively worse over the next few days, so he presented to the emergency department. He was triaged and admitted for intravenous antibiotics as at the time there was no capability for Hospital in the home to undertake home visits to administer the treatment required.

Mark's journey

Mark, a 40-year-old living in a rural area was on monthly antipsychotic depot intramuscular injections since being diagnosed and living with schizophrenia. Mark regularly attended the local depot clinic however had forgotten to attend the last clinic and started to develop breakthrough symptoms. Mark called an ambulance due to hearing increasing voices and the ambulance attendees were able to administer a one-off dose of medicine for the breakthrough symptoms. A community mental health RN visited Mark at home to follow up on the emergency call and undertook a full assessment noting Mark's change in behaviour. The RN knew Mark and had already established rapport having worked in the depot clinic that Mark had attended and was aware that Mark had insight into the situation and required treatment. The RN had access to Mark's medical history and treatment including dose, date and site of the last injection. The RN knew that Mark did not like presenting to the hospital and could get volatile when presenting to the hospital setting. The RN however had no option in the situation other than to advise Mark to present to the emergency department to be triaged in order for Mark to receive further breakthrough medication for his symptoms as required. No clinics were available to Mark in the area for another two weeks and his regular GP was away during this time.

Jose's journey

Jose, an 89-year-old resident in an aged care facility had become constipated. A full assessment was made by the clinical RN in charge of residents' care and determined that Jose needed additional hydration and oral medicines which needed prescribing to alleviate his constipation. Due to no GP being available to visit for a fortnight and no NP structure available at the residential aged care facility, Jose was transferred to the nearest emergency department for further assessment and treatment. Jose was given medication in emergency and intravenous fluid before being discharged back to the aged care facility.

Henry's journey

Henry, an 82-year-old resident of an aged care facility had tested positive to COVID-19. His COVID-19 diagnosis was within the acceptable time-period for administration of antiviral medicine. The RN in charge engaged with telehealth services for initial treatment however a prescription for the antiviral medication was required. The aged care facility was unable to access a GP within the 24-hour timeframe required for the antiviral treatment and as a result Henry's condition deteriorated. Henry was subsequently transported by ambulance to the nearest emergency department for admission.

Cathie's journey

Cathie, a 46-year-old woman with type 1 diabetes resided independently in her own home in rural Queensland. Cathie was under review from a locum GP as she had been feeling very drowsy in the mornings and her blood sugars were dropping to low levels. The locum GP felt a review of her insulin medicine regime was necessary and consulted an RN credentialed diabetic educator (CDE) for advice. On review and assessment by the RN CDE, it was noted that Cathie required an insulin dosage change. The RN CDE consulted with the locum GP to advise on this requirement for change so a prescription could be written and filled on the RN CDE's advice. Cathie had a prescription filled by the pharmacist and the RN CDE revisited Cathie at home once the script was filled to review her progress and blood sugar levels. On review it was noted further dosage change was required and the RN CDE was again required to provide

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further treatment advice to the locum GP. Cathie was advised to revisit the locum GP once again for these changes to be made. Cathie felt frustrated at having to revisit the locum GP and wondered why the CDE RN who was managing her treatment regime in collaboration with the GP and specialised in diabetes management could not do this in her home.

There is a need for more timely, convenient and equitable patient access to medicines to improve the experiences and outcomes for health consumers in Australia.

2. Why is Government action needed?

Australian governments are committed to ensuring that all Australians, including those in aged care, disadvantaged communities and live in rural, regional and remote parts of Australia 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. This includes the approach 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.

As the national regulator, the NMBA has the expertise to regulate nursing practice and this could overcome the unknown degree of risk that currently exists with current national inconsistencies where an RN with no additional training or preparation through supply causes can prescribe medicines.

The NMBA has worked collaboratively with the Australian Nursing and Midwifery Accreditation Council (ANMAC) in developing the new national Registered nurse prescribing accreditation standards in preparation for the introduction of designated RN prescribing. These accreditation standards ensure designated RN prescribers have the knowledge and skills to meet the [NPS National Prescribing Competencies Framework](#) in order to prescribe medicines judiciously, appropriately, safely and effectively.

Health Ministers have governing responsibilities under the National Scheme including approving registration standards for the endorsement for scheduled medicines. 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 D-RIS to be endorsed with Ministerial approval, governments will need to assist by working towards a uniform and coregulatory approach of state and territory drugs and poisons legislation as currently there is lack of legislative consistency which could impede timely access to medicines for patients and further contributes to RNs working below their scope of practice.²⁰ A nationally collaborative approach is required to resolve these issues in the best interests of access and equity for patients and clients.

Governments also have an interest to ensure that their regulatory frameworks achieve their stated objectives, including through the National Scheme which is founded on the National Law. Governments have indicated that RNs should be able to work to their full capability and scope of practice competently to address health inequities 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 to their full scope in order to meet community needs and provide models of care to improve access and quality of care.^{62,63}

Additionally, the 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.⁶⁴

At their November 2023 meeting Health Ministers reaffirmed their commitment to national health workforce reform and Ministers have agreed to support all recommendations from the Kruk review report, with several recommendations to urgently improve registration pathways for international health practitioners.⁶²

For this reform to occur it is imperative that policies and processes are current, flexible 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 in reflecting healthcare issues. 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 the care that a patient needs. The Minister also touched on a pertinent point, “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 scope of practice”.⁶⁵

The *Unleashing the Potential of our Health Workforce Review* was formally announced on 28 August 2023 and affirmed the need to optimise the health workforce across a stretched primary care sector, boosting health access and equity across all communities with a particular focus on regional and remote areas.^{66,67} This review will provide a focus on RNs who are currently underutilised in the delivery of quality healthcare and are currently not able to work to their potential or full scope of practice.

This can be achieved by support in making better use of RNs’ skills and knowledge through designated RN prescribing. 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 palliative care services, mental health and hospital settings and in settings with communities who do not always have access to mainstream services. Reduced access to quality healthcare contributes to individuals experiencing, in general, poorer health outcomes.

RNs are the largest healthcare workforce in Australia. The introduction of designated RN prescribers who are suitably educated and trained to prescribe would allow the provision of timely, safe and affordable access to a high-quality and reliable supply of medicines and medicines-related services for all Australians. This could create an environment where medicines are used safely, optimally and judiciously, with a focus on informed choice and coordinated person-centred care. Non-medical prescribing may contribute to the delivery of sustainable, responsive and affordable access to medicines.^{2,68,69} It may reduce costs, increase access, and improve outcomes for patients without compromising safety and quality.^{2,70} It promotes a flexible workforce, which is an important initiative to ensure consistency of healthcare delivery as the Australian population ages.^{2,69}

There is considerable scope for innovative approaches to improve healthcare. Allowing appropriately trained and supported RNs 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 and can assist in building workforce capacity and sustainability.

An ageing population increases in chronic health and comorbidities as well as the impacts of the COVID-19 and subsequent long COVID have contributed further to issues in the healthcare system. A strategic and innovative approach in the form of complementary reform in line with current health strategies and

initiatives is required to address these inequalities. Providing 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 is crucial to improving health outcomes.

Government action is needed to enable RNs to expand their scope of practice to prescribe schedule medicines through the introduction of the proposed Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber.

Government will be required to work through the barriers that have been identified in the scope of practice review such as harmonisation of the drugs and poisons legislation, support of education and training for RNs and the review of funding towards education and training. Ensuring that education and training is accessible and that RNs are incentivised to undertake it will allow RNs to acquire the knowledge they need to work to full scope of practice. This will also include review of the Medicare Benefits Schedule for access to increased services in primary practice and the current Pharmaceutical Benefits Scheme that allow equity in access to medicines without financial disadvantage to primary health consumers in the space of RN designated prescribing. It is important to note that whilst the Commonwealth has some levers, it is working closely with the States and Territories collaboratively on expanded scope of practice projects which include federal and financial arrangements to ensure effective policy partnership in increasing the scope of practice.⁹

The introduction of designated RN prescribing aims to address several key problems and multifaceted challenges within the healthcare system. An additional workforce with expertise in medicines management and the ability to prescribe has the potential to facilitate safe and improved access to medicines for all Australians. There is a case for designated 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. After further wide-ranging public consultation that have provided the opportunity to test the strengths and weaknesses of the options outlined and address any additional impacts options that were not originally considered, this can now be achieved.

This is a problem that the free market cannot resolve and intervention from government is needed in order to enable nurses to work to their full scope of practice. In turn, this is expected to contribute to the current workforce, future workforce sustainability and will increase the satisfaction and add value to the registered nurse role through the NMBA's 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 and produce positive changes to a situation that currently directly contributes to health inequities and subsequently through this implemented innovative intervention can improve outcomes in the patient's journey.

3. What policy options are you considering?

3.1 Option 1 – Retain the status quo

This option would mean that there are no changes to the current prescribing arrangements in Australia. No regulatory action or legislative change would be required and access and equity to healthcare and medicine in metropolitan, rural and remote areas would remain unchanged.

There would be continuation of risk posed by inconsistent education and governance requirements for RNs who are authorised to 'supply' through state regulations.

Additionally, by maintaining the status quo through not enabling RNs to work to their full capability and scope of practice, the government objectives and initiatives under the National Health Care Agreement 2022, The Stronger Rural Health Strategy, the Future Focused Health Care Plan and Australia's National Medicines Policy would not be met.

The option to retain the status quo also does little to follow the recommendations that came out of the [Royal Commission into the Aged Care Quality and Safety Final Report](#), in continuing work on the National Agreement on Closing the Gap to ensure Aboriginal and Torres Strait Islander People have increased access to health and achieve better outcomes, or the National Health Act 1953 which saw reforms made with the intent to improve access to medicines to Aboriginal and Torres Strait Islander People.

Australia has a signatory to the Declaration of Alma Ater and the Sustainable Development Goals. Under these declarations it is a human right for appropriate and timely access to medicine. These objectives cannot be met by maintaining the status quo.

3.2 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 the proposed Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber to Health Ministers for approval. RNs with this endorsement would be called **designated RN prescribers**.

The proposed registration standard would allow for RNs who successfully complete an NMBA-approved postgraduate qualification to prescribe Schedule 2, 3, 4 and 8 medicines as a designated RN prescriber, under supervision and in collaboration with an authorised health practitioner, to patients and clients.

Nurses are the largest cohort within the healthcare workforce and work with a range of populations in a variety of settings and are integral to all areas of healthcare. Expanding the RN scope of practice provides a real opportunity for the development of innovative models of care, that includes prescribing, to improve equity and access for all Australians to medications and comprehensive, collaborative holistic healthcare that is not fragmented.

Designated RN prescribing can help address shortages of primary care providers, especially in rural and underserved areas. It expands the workforce capabilities of providing essential healthcare services, making it easier for patients to receive timely treatment. Streamlined healthcare services that can be provided through designated RN prescribing can lead to more efficient and timely patient care through collaborative approaches with GPs and NPs.

Designated RN prescribers could prescribe medicines promptly, reducing delays in treatment and improving patient satisfaction. Continuity of care would be extended as RNs often have a deeper understanding of their patients' medical histories and health needs and can ensure a more seamless continuity of care and better integration of treatment plans. Designated RN prescribers could potentially improve chronic disease such as diabetes or hypertension through review, adjustments and close monitoring and assessment whilst providing education on medication adherence and lifestyle changes. Designated RN prescribing through a framework of collaborative practice with GPs, NPs, patients/clients and their families ensures that any prescribing decisions are promoting safety with accountability. Additionally, RNs are skilled educators who can provide patients with essential information about their medicines, potential side effects, and how to take them properly. This can result in enhanced patient compliance and safety.

Decision regulation impact statement: Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber

3.3 Option 2a – Enable RNs to expand their scope of practice to prescribe Schedule 2, 3, and 4 medicines

During the development of the proposed model of prescribing and earlier consultation with stakeholders, consideration was given to whether the endorsement should extend to Schedule 8 medicines. Several stakeholders raised concerns about the inclusion of Schedule 8 medicines due to the higher risk for potential for misuse, abuse and dependence associated with these medicines. There was also mixed feedback from key stakeholders such as the Chief State and Territory Nurses, The Australian College of Nurses, The Australian Nursing and Midwifery Federation, Australian Primary Nurses Association, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, RNs and health services 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. This feedback was prevalent across areas of practice such as palliative care, mental health, community, rural, remote and emergency areas. In response to these concerns Option 2a proposes that the proposed registration standard would be limited to prescribing only Schedule 2, 3 and 4 medicines. This option would otherwise include all the requirements described in Option 2.

3.4 Option 2b – 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 proposed registration 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.

The NMBA is currently consulting on proposed Guidelines for privately practising nurses. These guidelines have been developed to provide best practice for nursing services delivered in a private practice setting. A requirement of the proposed guidelines is that privately practising nurses (PPNs) must only deliver evidence-based services which considers previous treatments and responses to therapies (whether prescribed or non-prescribed). In keeping with the Quality Use of Medicines principles, PPNs are to follow a systematic evaluation process when considering, recommending or prescribing evidenced based medicines, therapies and services. PPNs must also comply with the relevant state and territory drugs, poisons and controlled substances.

In relation to cosmetic injection the NMBA considers that the administration of cosmetic injections is within the scope of appropriately educated RNs. It requires a detailed assessment and planning of care, complex anatomical and physiology knowledge as well as decision-making relating to pharmacodynamics and pharmacokinetics. RNs performing cosmetic injections must ensure safe and appropriate administration in accordance with best practice and clinical governance frameworks. At present the person receiving the cosmetic injections:

- must have a consultation and assessment with a medical practitioner or NP, who is located in Australia, in line with the above
- is only treated by nurses with the appropriate education, skills and knowledge, utilising up-to-date knowledge of regional anatomy and safest practice
- is in a clinical setting that meets acceptable healthcare quality and safety standards, and
- is aware of arrangements in place to receive post procedural care

Nurses are responsible for making professional judgements about when an activity is within their scope of practice and, when it is not, for initiating consultation and collaboration with, or referral to, other members of the healthcare team.

The NMBA's standards, codes and guidelines set the regulatory requirements within which nurses working in the area of cosmetic medical procedures must comply as with all contexts of clinical practice, to ensure ongoing competence and safe practice. This includes but is not limited to:

- The relevant standards for practice
- [Registered nurse standards for practice](#), and

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- [Registration standard: Professional indemnity arrangements](#)
- [Code of conduct for nurses](#)
- [Decision-making framework for nursing and midwifery](#)
- [Safety and quality guidelines for nurse practitioners](#)
- [Guidelines for advertising regulated health services](#)
- [Advertising compliance and enforcement strategy for the National Scheme](#), and
- [Telehealth guidance for practitioners](#)

Whilst these areas are highly monitored and regulated in response to these concerns, the proposed registration 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.

4. What is the likely net benefit of each option?

4.1 Option 1 – Retain the status quo prescribing practice

Impacts to consumers

This option would not facilitate improvements in access to healthcare or health service delivery for people seeking healthcare and those vulnerable and marginalised communities within Australia. The status quo would 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.

Costs of maintaining the status quo

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.³ Furthermore, 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.

The option to retain the status quo does little to follow the recommendations that came out of the [Royal Commission into Aged Care Quality and Safety Final Report](#)⁵⁰ which recommended:

- Care should be provided in an environment which protects older people from further risks to their health and should include the opportunity for in home care to prevent deterioration and potential hospital admission which causes distress for the resident
- To provide a system of aged care based on a universal right to high quality, safe and timely support and care that exemplified dignified living
- The portion of best practice in aged care and the use of contemporaneous and innovative continuous improvement of which designated prescribing is one

Retaining the status quo does not support the International Council of Nurses plan for policy action to support nurses to work to their full scope and practice nor does it support the Australian Government's *Unleashing the Potential of our Health Workforce Review* which aims to optimise the health workforce to improve health access and equity across all communities – including regional, rural and remote areas.^{9,66}

To date there is very little global quantitative evidence related to cost benefit analysis available for non-medical prescribing, including NPs.^{71,72} As such, it is difficult to be able to provide anything other than a hypothetical cost benefit analysis related to maintaining the status quo or other options in Australia and other countries where RN prescribing is well embedded and prevalent as part of healthcare structures and systems.

The NMBA 31st July 2023 sought advice from Dr Gigi Lim from the University of Auckland. Dr Lim who has continued involvement in education and expansion of the RN prescriber role in New Zealand since its inception in 2006. The NMBA reached out to Dr Lim after consulting with the Chief Executive/Registrar of

the Te Kaunihera Tapuhi, Aotearoa, Nursing Council of New Zealand as literature searches proved unsuccessful in yielding data associated with recent quantitative results around cost benefit analysis related to RN prescribing. Dr Lim confirmed there are no studies that have investigated the cost benefit analysis of RN prescribers in New Zealand however welcomes participation from the NMBA in future studies supported by the School of Business, University of Auckland and with RN prescribers and GPs.

[A case study methodology has been used to highlight the journey of patients and their families with associated costings from maintaining the status quo. Case study: George’s journey](#)

George, a 77-year-old with a history of anaemia and bowel malignancy was being treated for symptom management by only a community palliative care nurse consultant. George lived at home with his wife who was his primary carer when his condition suddenly deteriorated. His wife called an ambulance and George was taken to the emergency department. After waiting in for two hours on a trolley and not being seen, at the request of the Family and Medical Power Attorney, George returned home. The community palliative care nurse consultant was called to visit George in his home to make further assessment and initiate a management plan however George’s regular GP was unable to visit to review his medications. The RN was distressed with the situation and chose to drive to the GP to get an order for comfort measures until further review and treatment plans could be put in place.

Case study: Nellie’s journey

Nellie, an 85-year-old resident with new onset dementia living in an aged care facility had become increasingly confused. Nellie had a urine test collected for pathology and initial in-facility testing returned a urinalysis reading that indicated infection. The RN in charge undertook a full assessment of Nellie and knew Nellie had previously received treatment for urinary tract infections. A GP was unable to be contacted to review Nellie. The urine cytology results confirmed that Nellie had a urinary tract infection. Nellie’s electronic medical records noted previous antibiotic treatment for the same infection strain. The GP had also written that should this episode be repeated, the same cytology would be best managed with the same medicine which was noted in the EMR. During this time, Nellie’s condition had deteriorated, and she was transferred to hospital via ambulance. Nellie waited six hours in the emergency department on a trolley before being admitted to a medical ward with delirium secondary to urinary sepsis. Following her discharge from hospital, it took Nellie approximately 10 days to be re-orientated to her residential environment. A marked decrease in Nellie’s conditioning was noted by the RN at the facility accompanied by demonstrated poor behavioural outcomes.

Hospital admission costings

According to the Independent Health and Aged Care Pricing Authority’s *National Benchmarking Portal periodic insights* ⁷³ the average cost per episode for patients admitted to hospitals for acute care, sub-acute and non-acute care, emergency presentations and mental health are outlined in Table 1 below.

Acute care admission to public hospitals account for the majority of costs. Costs includes formal admission to hospital to receive short-term treatment, treating illnesses or injuries, performing surgery or other diagnostic procedures.

Sub-acute or non-acute care patient admissions include specialised care services related to the optimisation of the patient’s functioning and quality of life. This includes rehabilitation and palliative care.

An emergency department presentation includes the service provided to a patient in a hospital’s emergency department without admission.

Table 1: Average cost of emergency department visit, hospitalisations and transfers for acute care

Resource	Description	Value	Source
Transfer to emergency department	Emergency transport	\$1,358 Metropolitan \$2,004 Rural	National Average excluding QLD and Tasmania
Transfer to emergency department	Non-emergency transport	\$367 Metropolitan \$620 Rural	National Average excluding QLD and Tasmania

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Resource	Description	Value	Source
Emergency department presentation	Cost associated with emergency department presentation	\$791	Independent Health and Aged Care Pricing Authority – National benchmarking portal cost per national weighted activity unit 2020-21 data
Hospitalisation	Cost associated with acute care episode	\$5,273	Independent Health and Aged Care Pricing Authority – National benchmarking portal cost per national weighted activity unit 2020-21 data
Hospitalisation	Cost associated with sub-acute and non-acute Care episode	\$17,973	Independent Health and Aged Care Pricing Authority – National benchmarking portal cost per national weighted activity unit 2020-21 data
Hospitalisation	Cost associated with mental health episode of care	\$19,831	Independent Health and Aged Care Pricing Authority – National benchmarking portal cost per national weighted activity unit 2020-21 data

If the status quo is maintained there will be a continued increase in potentially preventable hospitalisations (PPH) where designated RN prescribing may have been able to fill the gap between primary care and the need for presentation to an emergency department.

According to an Australian Institute of Health and Wellbeing report, in 2020 the rate of PPH was 2,800 per 100,000 people. The dataset also highlighted that people aged 65 years and over accounted for almost half (46%) of all PPH and Aboriginal and/or Torres Strait Islander people experienced PPH at a rate three times as high. Of this population, in the period July 2017 to June 2019, there were 92,019 hospitalisations that were potentially preventable. These hospitalisations could have been avoided through appropriate treatment interventions.⁷⁴

Presentations to the emergency department result in increased healthcare costs. If the status quo is maintained there will be no reduction in presentations to the emergency department in situations where designated RN prescribers could have potentially contributed to avoiding health service usage and maintained the wellbeing of the patient/client in their own familiar surroundings.

Hospital presentations and PPHs negatively affect the morale and quality of life of patients and their families.⁷⁵ While some hospital presentations and admissions are required or unavoidable, in the above cases outlined access to a designated RN prescriber could have provided timely and effective care.

Reducing hospitalisations amongst older Australians has been a key government priority and there has been a body of evidence that suggests people with dementia are at greater risks of poorer outcomes during hospitalisations which increasingly leads to adverse events, readmissions, and mortality. In an Australian study, a group of older outpatients with a mean age of 78 years reported a lower health related quality of life (HRQoL) associated with increased hospital admissions.^{76,77}

In 2021–22, there were almost 280,200 mental health related public hospital emergency presentations. Aboriginal and Torres Strait Islander people account for 13% of these presentations despite comprising of approximately 3% of the Australian population. This percentage was 4.6 times higher than the rate of non-indigenous Australians reporting to the emergency department for mental health-related presentations (443 vs 95 per 10,000 population).⁷⁸ Mental health disorders are increasing globally, as is the body of evidence to suggest that emergency departments are not appropriate nor effective in responding to people with mental health conditions due to their overly stimulating environments, decreased privacy and being staffed with healthcare professionals with little or no expertise and training in mental healthcare.^{79,80}

Mental health patients also reported being judged and not being treated the same as patients with more obvious physical health presentations.^{79,80}

Everyone has the right to die with dignity and many people in the western world have expressed a wish to receive end of life (EOL) care at home. In Australia it is estimated that 60 to 70 per cent of Australians would prefer to die at home, however only 14 per cent do so. The vast majority of Australians die within a hospital or residential aged care setting.⁸¹ Providing EOL and palliative care in the emergency department is challenging with patients often receiving invasive or neglected care as they present as non-acute. Palliative care is not well integrated into this setting^{82,83,84} and whilst there are many established, coordinated and dedicated services to support EOL and palliative care services in the community, there are patients whose care journey could have been better assisted through a collaborative person-centred care approach in their final stages. In the patient journeys of Charlie and George, a designated RN prescriber may have been able to provide a holistic episode of care. This could have prevented the moral distress and suffering experienced by the patient and their families and preserved dignity in dying. Access to a designated RN prescriber could also facilitate improved outcomes in residential aged care settings as these settings often face unique challenges in administering palliative care services.⁸⁵

There were reported increases in quality adjusted life years (QALY) in a 2018 KPMG nurse practitioner study of cost benefit analysis undertaken in 2018. This was through reduced emergency presentations and hospitalisations. QALY is a generic measure of disease burden, including both the quality and the quantity of life lived.⁸⁶ The use of QALY as a measure could be used to evaluate the impacts of designated RN prescribing once implemented.

Access to essential medicines is identified as a human right under the *International Treaty of Social Economic and Cultural Rights*. It is also underpinned by the *Declaration of Alma Ata* and the *Sustainable Development Goals*.²⁰ Maintaining the status quo does not reflect or align with these universal interventions that ensure adequate healthcare for all.

There is also a risk that maintaining the status quo will lead to highly qualified nurses will leaving the sector due to lack of career progression and systems where RNs are unable to work to their full potential and scope of practice in the delivery of safe patient centred care as per the International Council of Nurses Report, *Recover to Rebuild: Investing in the Nursing Workforce for Health System Effectiveness*.⁸

Benefits of maintaining status quo

There were no identified benefits in the literature for maintaining the status quo however the following benefits were identified in the feedback to the C-RIS:

- to focus on increasing the RN workforce and expanding the nurse practitioner models
- avoid the burnout of RNs
- generate more income for medical practitioners
- maintain high quality safe prescribing

4.2 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.

Benefits of expanding the scope of practice of RNs to prescribe Schedule 2,3,4 and 8 medicines under supervision/designation

This option enables interprofessional teams and innovative models of care to address the identified current issues in healthcare. These include healthcare backlogs as a result of the COVID-19 pandemic, illnesses arising from non-attendance or inability to access care during the COVID-19 pandemic, anticipated healthcare issues related to COVID-19 waves, surge requirements in healthcare, the increase of chronic comorbidities and an ageing population. This option can address 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 affect retention and allow for flexibility and deployment to areas of high need.⁸

Evidence from international studies shows that RNs who are educated and authorised to prescribe, do so safely and effectively within their scope of practice.^{29,30,31,32,36,59,71} 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.

RNs who are credentialled diabetes educators (CDE) provide expertise in diabetes treatment and management guidance. RN CDEs are currently required to complete an accredited Australian Diabetes Education Australia (ADEA) Graduate Certificate in diabetes education and management which entails 1,000 hours of practice in diabetes education, and a minimum six-month mentoring program by an experienced RN CDE. In regional and remote areas across Australia, RN CDEs are often consulted by medical practitioners. Medical practitioners seek advice on their patients' social and medical history and best practice clinical framework in diabetes regarding overall management of diabetes treatment including medicines management, review and titration as RN CDEs work through all aspects of the medication management cycle. In circumstances where GPs are reliant on the input of RN CDEs, there may be fragmented care without continuity which can introduce risk for the patient in their treatment plan.

Nurse prescribers have been considered safe and there appears to be little difference between RN and medical practitioners with regards to the type and dose of medications prescribed. Further to this a systematic review of RN prescribing concluded that the effects of RN prescribing, and patient outcomes were similar or better when compared to medical practitioners and facilitated better patient care.^{72,87,88} RN prescribing has been referred to as 'one of the most exciting initiatives in the recent history of nursing'.⁸⁸

Despite the successful introduction of the *Registration standard: Endorsement for scheduled medicines for midwives* in 2016 which allows for suitably qualified midwives to be endorsed to prescribe schedule 2, 3, 4 and 8 medicines, RN prescribing has not been integrated into Australian healthcare. This leaves Australia lagging behind in innovative models of healthcare that increase access and equity for all Australians and allows those RNs who chose to do so, and with an endorsement, to work to the top of their scope. The designated RN prescriber works within a clinical governance framework compliant with Quality Use of Medicines (QUM) to a prescribing agreement established by the organisation or employer, not detracting from those already authorised to prescribe autonomously.

Impact on health consumers

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

There may however be a financial cost to consumers for medicines prescribed by a designated RN prescriber if the medicines are not subsidised by the PBS. There is also the potential risk of fragmentation of healthcare if the designated RN prescriber and the authorised health practitioner do not take a coordinated approach to the provision of care. This risk will be mitigated through the development of the prescribing agreement that is required as a part of the proposed model of prescribing, underpinned by a patient centred collaborative approach to clinical care. This risk mitigation strategy will be supported through the integration of clinical governance of the health care organisation and the required Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standard communicating for safety relevant to the healthcare organisation. This standard across any context of care describes the systems and processes to support effective and coordinated communication which continually support the delivery of safe patient care.¹⁹

Impact on health organisations and services

Health services seeking to introduce designated RN prescribing would have to develop a governance framework. There will be a time impost for 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 including:

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

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- education of other health practitioners about the role that they play in the model.
- potential increase to their insurance premiums as a result of enabling RNs to prescribe.
- an additional cost in wages as RNs with the endorsement would be eligible in each state and territory for a qualification allowance for postgraduate studies.
- health services may need to backfill staff who take time off for study to undertake the postgraduate qualification however many Higher Education Providers (HEPs) choose to offer courses online in a hybrid model that would allow RNs to work and study at the same time.

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 health consumers. For hospitals, there may be reductions in length of stay for inpatients, more timely discharge and therefore a decrease in cost of care for health organisations.

The ability for designated RN prescribers to provide care to some patients has the potential to free up health practitioners within health services to focus on more complex patients which leads to a more effective use of resources.

Impact to nurse practitioners

There will be a time impost for NPs who choose to work in collaboration with designated RN prescribers as the authorised health practitioner. These NPs would need to provide support and clinical supervision to the designated RN prescriber as well as input in establishing a clinical governance framework relevant to the health care setting.

Whilst some NPs have raised concerns in the literature regarding the designated RN prescribing role eroding or impacting on the NP role,⁸⁹ the NMBA perceive this to be a collaboration and that NPs harness the challenges that they have faced with regards to professional role recognition and scope in a medical led model, to support RNs. This could strengthen nurse led models of care that improve access and equity, encouraging articulation of suitable designated RN prescribers to the NP role through educational pathways offered by accredited higher education providers. This could also assist in succession planning for the NP workforce.⁸⁹

There will be no impact to the current prescribing practices by NPs as they work under Model 1 of the HPPP, autonomous prescribing.

Impact to general practitioners

There will be a time impost for GPs who choose to work with a designated RN prescriber under a prescribing agreement. These GPs would need to provide support and clinical supervision to the designated RN prescriber as well as input in establishing a clinical governance framework relevant to the health care setting.

Medical practitioners will need guidance on the designated RN prescriber scope of practice. Clear role delineation would need to be established for health professionals, health consumers and the public around the roles. The NMBA would make this delineation clear through their scope of practice document available on the Ahpra and NMBA website.

The prescribing agreement is a key document for the designated prescribing model and will be a written agreement between the designated RN prescriber and the medical practitioner and approved by the health organisation/service or employer.

There will also be an initial and ongoing time impost for clinical supervision as model 2 of Health Professional Prescribing Pathways warrants prescribing under supervision. This aligns somewhat with the RACGP *Position on independent non-medical practitioner prescribing* where prescribing occurs under the direction and supervision of a medical practitioner. This arrangement will help ensure compliance with best practice, prevent the occurrence of adverse events and maintain continuity of patient care.⁹⁰

RNs with expertise, working at an advanced level in a specific context of care who undertake postgraduate qualifications that lead to endorsement as a designated RN prescriber are able to work

within an interprofessional collaboration with all medical practitioners in promotion and management of health and wellbeing. These integrated and innovative approaches can meet increased care demands and improve overall access and equity to healthcare. However, it is acknowledged that this may be a challenge for some medical practitioners and their professional identity and there are nurse prescribers who perceive that doctors feel that prescribing rights of nurses are a threat and should be exclusive to their own profession.²⁷

Impact to registered nurses

RNs who are educated and authorised to prescribe medicines have improved work satisfaction as they feel they are able to fully meet the needs of their patients, they have improved collegiality with other health practitioners and increased career opportunities which enhance positively on retention.⁸⁹ There has been much interest in the role of the designated provider since the original symposium in 2016. The ANMAC project working group has identified education providers who are already interested in developing courses. There are 13 accredited and NMBA approved NP course and there are 96 courses that offer the Bachelor of Nursing Programs. All of these courses are well placed to put forward the new postgraduate diploma course given that they already have the foundations required to meet the RN prescribing accreditation standards in the undergraduate degree and in the Master of NP program.

This option has the potential to reduce the moral distress felt by many RNs who hold the knowledge, skills and understanding of the patient in order to prescribe in many situations but are not able to due to scope of practice restrictions.

Education costs – The RN prescribing education is yet to be fully determined, however the current cost for the postgraduate 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. There may be a cost imposed by unpaid leave and travel to undertake study if accredited programs do not utilise of hybrid model of education where students can participate in online education.

Endorsement costs – a one off application \$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 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 the scope of practice under the prescribing agreement. A review of current insurance premiums for RNs through membership or affiliation links indicate 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.

Impact on governments

In order to implement designated RN prescribing, each state and territory would need to review and amend their respective drugs and poisons legislation. They will also need to create a requirement for the development of policies and guidance for public health services.

A review of the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) would need to be undertaken by the Commonwealth Government in order for designated RN prescribing to deliver its potential benefits of equity and access to care. Currently under the *National Health Act 1953*, pharmaceutical benefits can only be prescribed by medical practitioners, nurse practitioners and endorsed midwives. Nurse practitioners and endorsed midwives apply for approval to become PBS prescribers.

Additionally, the Pharmaceutical Benefits Advisory Committee (PBAC) responsible for making recommendations to the Minister for Health regarding medicines for prescribing, would need to include

representation from endorsed RNs. This would be beneficial to track and evaluate outcomes of designated RN prescribing.

A recommendation of the *Unleashing the Potential of our Health Workforce – Scope of Practice Review*, is aimed at removing barriers to enable health practitioners to be able to work to their full scope to provide quality care services and greater access and equity to primary care.

While the above activities are beyond the regulatory remit of the NMBA. The NMBA would welcome the opportunity to provide input to assist with the changes required to enable the smooth and successful implementation of designated RN prescribing across Australia.

The NMBA anticipates that there would not be a large net increase in the number of medicines prescribed as some consumers would have previously had medicines prescribed by a medical practitioner or a nurse practitioner. The increase would be seen with new presentations and in line with growth and requirements in healthcare.

Cost benefit analysis

It is difficult to undertake an 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. The consultation questions within the C-RIS were developed to gather further information from stakeholders on the potential costs and benefits associated with the options presented. The consultation feedback yielded results that correlate and support the international literature to date that describe studies which largely focused on assessing the benefits and effectiveness of non-medical prescribing without consideration of the costs, economic benefits and resources required.^{71,72}

Further, it is difficult to undertake a cost benefit analysis without complex modelling by health economists. The economic evaluation cited in the below tables outlines the costs for admission to emergency and hospitalisations. Designated RN prescribing is likely to yield cost benefits to health services through reduced emergency department visits, hospitalisations and improved hospital flow. Another important benefit will be to patients and health consumers' quality of life and their experiences afforded by this opportunity. Designated RN prescribing will enable some patients to have treatment in their homes and their communities, rurally and remote or where appropriate, equally and with greater access.

The value of designated RN prescribing is evident when reviewing cost of emergency department visits, hospitalisations, transfers for acute care and experiences of health consumers and their families.

However, tools to evaluate the costs of monetary value is difficult to quantify for the following reasons:

- PBS and MBS services for designated RN prescribers are not available which would impact on data to inform a cost benefit analysis in primary care
- There has been no pre or post evaluation undertaken in any of the countries where RN prescribing has been implemented
- There is very little quantitative data related to RN prescribing and length of stay and the literature available is outdated
- There is no adequate quantitative data related to RN prescribing and reduced emergency department visits or hospitalisations
- The designated RN prescribing model has not been introduced in Australia and whilst the NP role was introduced in 2000, no cost effectiveness analysis, cost unit analysis or cost benefit analysis has been undertaken. The majority of research to date has been around clinical effectiveness and patient outcomes.

Quality adjusted life years (QALYs) and life years gained is a measure commonly used in international studies related to international pharmacist and non-medical prescribing^{71,72}. In the 2018 KPMG Australian NP model of care cost benefit analysis it was estimated that there were QALY gains from NPs.⁸⁶ It would be prudent of the government in future to undertake a cost benefit analysis in monetary terms using the disability of adjusted life years (DALYs), QALYs and additional sensitivity analyses such as the value of

statistical life years gained (VSLY).⁹¹ This could quantify the effects of designated RN prescribing and the impact of NPs.

A hypothetical cost benefit analysis has been formulated for designated RN prescribing with a wider health system perspective. This analysis has been guided by the literature and data from the Australian Institute of Health and Wellbeing and the Independent Health and Aged Care Pricing Authority.

The case-based scenarios presented earlier in Option 1 are re-presented with the inclusion of a designated RN prescriber to provide a direct comparison of patient management with a designated RN prescriber involved in the episode of care. There are also new scenarios that highlight the value on designated RN prescribing that have been provided directly from clinicians.

Case study: Nellie's journey

Nellie, an 85-year-old resident with new onset dementia living in an aged care facility had become increasingly confused. Nellie has a urine test collected for pathology and initial in-facility testing returns a urinalysis reading indicating infection. The RN in charge is endorsed as a designated RN prescriber and reviews Nellie's history before undertaking further examination to rule out other causes for the confusion and diagnoses a UTI based on additional pathology sensitivities. The designated RN prescriber consults with the facility's NP (identified in the prescribing agreement) via telehealth to discuss Nellie's case. A collaborative decision is made that Nellie commence on oral antibiotics and paracetamol. The designated RN prescriber completes the medication chart. A copy is sent to the pharmacy and the pharmacist reviews the order, prepares, and dispenses the medication to the facility where an RN administers the first dose and monitor for any signs of allergic reaction. Nellie's family have been contacted during the process and are aware of the updates on Nellie. Nellie is reviewed 24 hours after commencing the antibiotics by the designated RN prescriber. Three days after commencing the antibiotics Nellie's acute confusion had resolved.

Case study: Charlie's journey

73-year-old Charlie lives at home with end stage liver failure and encephalopathy. Charlie's condition deteriorated quickly on the weekend. Charlie was being cared for by the community palliative care nurse consultant who was also a had an endorsement for scheduled medicines for RNs. Discussions with the family regarding Charlie's wishes had occurred at the commencement of care eight weeks ago. Charlie becomes terminally agitated and distressed which also caused immense distress to the family. At the time no palliative care medications were in place. The community palliative care nurse consultant was called by the family and was able to visit Charlie with his family present to review and examine Charlie and revisit both Charlie and the families wishes. The RN calls the GP via telephone to provide a handover of the situation and to discuss the wishes of the patient documented in the history. The RN and the GP agree collaboratively that a syringe driver be commenced using morphine and midazolam and the RN prepares a script according to the schedule 8 drugs requirements and sends this to the local hospital pharmacy. The pharmacist reviews the order, prepares, and dispenses the medication. The syringe driver is commenced by the palliative nurse consultant also follows up with Charlie's family by phone at the end of the shift to assess Charlie's comfort. Charlie is visited twice a day by the endorsed palliative care nurse until his death 2 days later. Charlie was able to die in his home with dignity surrounded by his wife and family.

Case study: George's journey

George was a 77-year-old with a history of anaemia and bowel malignancy being treated for symptom management only. George lived at home with his wife who was his primary carer and he deteriorated quickly at home. His wife called the GP on locum assignment who referred a palliative care nurse consultant attached to the clinic with an endorsement for scheduled medicines to review George in his home. The RN reviewed and assessed George and spoke extensively to his wife and his son who was the medical power of attorney. The RN spoke with the GP to discuss the consultation with George's family and decided on a plan to commence a syringe driver of Glycopyrrolate, morphine and midazolam for pain and comfort in agreeance with the family and George's wishes. A collaborative plan was set out by the GP and the palliative care nurse and under indirect supervision the RN was able to complete the script and prescribe the medications. This was then sent to the pharmacy and couriered in a locked box only accessible by code by the RN. In the interim, the RN was able to educate George's family on the syringe driver, its use and what to expect. When the medications arrived, the RN was able to prepare the syringe driver for use. This is communicated to the wider team and documented.

Case study: Tarni's journey

Tarni is a 19-year-old Aboriginal and Torres Strait Islander female who presents complaining of lower abdominal pain for a few days. The designated RN prescriber undertakes a full patient history and nursing assessment as the patient has not had a health assessment for 12 months. This includes a diabetic screen as both parents have type 2 diabetes. A urine test, pregnancy test and sexually transmitted infection (STI) screen is undertaken based on the RN assessment. The STI screen is positive. The RN designated prescriber, under a supervised prescribing agreement, prescribes the required treatment which, if not prescribed, could result in severe pelvic inflammatory disease and evacuation to the hospital. Through timely assessment of Tarni's health status and appropriate response to her needs, including prescribing, the designated RN prescriber establishes a trusted relationship with the Aboriginal and Torres Strait Islander person and their family members. This resulted in encouraging ongoing service engagement which positively impacted on Tarni's health care outcomes. The designated RN prescriber works to enhance access to timely, holistic, responsive, and culturally safe care in the management of acute and chronic services in a rural Aboriginal community-controlled health clinic.

Case study: Mark's journey

Mark was a 40-year-old living in a rural area. Mark has been diagnosed with schizophrenia and is on monthly antipsychotic depot intramuscular injections (IM). Mark was usually a regular at the Depot Clinic, however had forgotten to attend the last clinic and had started to develop breakthrough symptoms. Mark called the local clinic in his area distressed with heightened behaviour. The community mental health RN who had an endorsement for scheduled medicines triaged his call and discussed the treatment options with a locum GP. A collaborative decision was made that Mark be prescribed his depot injection and be given oral medications for his breakthrough symptoms as required. The RN had access to Marks medical history and treatment. The RN prescribed the medication for Mark and sent this to the pharmacist who reviews the order, prepares, and dispenses the medication. The RN visited Mark at home having already established rapport through the clinic, undertakes a review and assessment. Mark is dispensed oral medication for breakthrough and an IM depot injection is administered. This prevented the need for Mark to travel over 1 hour to the hospital as Mark did not like presenting to the hospital setting. Mark was followed up again by the community mental health nurse. This is communicated to the mental health and interprofessional team and through both verbal and written documentation.

Table 2: Potential avoided costs of emergency department visit, hospitalisations and transfers for acute care

Resource	Description	Value	Source
Avoid transfer to emergency department	Emergency transport	\$1,358 Metropolitan \$2,004 Rural	National Average Excluding QLD and Tasmania
Avoid transfer to emergency department	Non-emergency transport	\$367 Metropolitan \$620 Rural	National Average Excluding QLD and Tasmania
Avoid emergency department presentation	Cost associated with emergency department presentation	\$789	Independent Health and Aged Care Pricing Authority – National benchmarking portal cost per national weighted activity unit 2020-21 data
Avoid hospitalisation	Cost associated with acute care episode	\$5,315	Independent Health and Aged Care Pricing Authority – National benchmarking

Resource	Description	Value	Source
			portal cost per national weighted activity unit 2020-21 data
Avoid hospitalisation	Cost associated with sub-acute and non-acute Care episode	\$16,118	Independent Health and Aged Care Pricing Authority – National benchmarking portal cost per national weighted activity unit 2020-21 data
Avoid hospitalisation	Cost associated with mental health episode of care	\$19,984	Independent Health and Aged Care Pricing Authority – National benchmarking portal cost per national weighted activity unit 2020-21 data

Table 3: Potential benefits

Potential benefits
Early intervention
Improved continuity of care
Reduced avoidable hospital presentations
Interprofessional collaborative acute/chronic management disease
Improved quality of life
Decreased moral distress of patients, family and healthcare professionals and the option to die with dignity
Improved access to health care for rural and regional areas
Improved access to health care services for Aboriginal and Torres Strait Islander Peoples
Deprescribing under supervision
Improved efficiency in primary health care
Improved efficiency and flow in emergency departments
Increased skill of RNs and recruitment and retention from increased satisfaction
Improved quality and safety

Table 4: Potential costs

Potential costs
Education
Professional indemnity insurance
Endorsement cost
Time cost for supervision and set up

If we analyse the potential cost savings using Mark’s Journey, there are also cost benefits associated for the government through the provision of designated RN prescribers. In 2021, there were 280,176 mental health-related presentations to ED departments for mental health related conditions. This is a cost saving of \$61.6 million in governments spending on potential care that could be provided by designated RN prescribers.⁷⁸

Cost saving through potential avoidance of Mental Health ED Presentations and Admissions
Avoidance of Mental Health Hospitalisations savings per patient \$19,984
Potential Cost saving \$21,988 per Mental Health ED presentations

If we analyse the potential cost savings using Charlie’s Journey who is a palliative care patient. There were 94,800 palliative care-related hospitalisations in public and private hospitals in 2021–22. We were unable to identify the length of hospitalisation of this number of patients or the number of patients who died within the ED.

Cost saving through potential avoidance of Emergency Admission per patient \$789
Cost saving through potential avoidance of Palliative Care Hospitalisations saving \$15 million

Further examples of where designated RN prescribing model may occur

The following examples describe further hypothetical scenarios where a designated prescribing model may be beneficial:

Example 1

A designated RN prescriber works in a health service as a part of a multidisciplinary team providing care to individuals 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 GP’s 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 telehealth 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.

4.3 Option 2 (a): enable RNs to expand their scope of practice to prescribe Schedule 2, 3, and 4 medicines under designation/supervision, in accordance with governance frameworks and prescribing agreements.

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. This increase has been reported to be due to their use in a range of types of chronic non-cancer pain, despite limited evidence of efficacy or safety for opioids in many of those patients. With levels of prescription opioid overdose at record levels in Australia and internationally, the TGA conducted a consultation in 2018 aimed at addressing prescription opioid use and misuse in Australia.⁹³ In addition, to reduce the harms and deaths from prescription medicines, States and Territories have introduced real time script. These databases monitor the prescribing of Schedule 8 medicines and medicines that are subject to abuse in real time and enable health practitioners to make safer clinical decisions about prescribing.⁹⁴

Impacts to Registered Nurses

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

Impacts to Consumers

Decision regulation impact statement: Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber

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 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.

Impacts to Healthcare Organisations and Services

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.

Impacts to Medical Practitioners and Nurse Practitioners

NPs and MPs would need to prescribe in addition to designated RN prescribers and would need to consult with patients in order for this to occur. This causes inefficiencies, increased time imposts for NPs and MPs to additionally consults in order to prescribe and will cause fragmented care that is not collaborative.

George's Journey demonstrates fragmented care when endorsed RNs are not able to prescribe Schedule 8 medicines:

Case study: George's journey

George was a 77-year-old with a history of anaemia and bowel malignancy being treated for symptom management only. George lived at home with his wife who was his primary carer and he deteriorated quickly at home. His wife called the GP on locum assignment who referred a palliative care nurse consultant attached to the clinic with an endorsement for scheduled medicines to review George in his home. The RN reviewed and assessed George and spoke extensively to his wife and his son who was the medical power of attorney. The RN spoke with the locum GP to discuss the consultation with George's family and decided on a collaborative plan to commence a syringe driver of Glycopyrrolate, morphine and midazolam for pain and comfort in agreeance with the family and George's wishes. The RN was not able to prescribe schedule 8 medicines and the options were to drive to the GP for the order to be written by the locum or to advise George's family to take him to present to the nearest hospital so that appropriate and timely care could be provided in order to keep George comfortable.

4.4 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. This could impact on RN credentialled diabetic educators (CDEs) working privately with GPs or specialists in the management and treatment of diabetes.

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.

5. Who did you consult and how did you incorporate their feedback?

The consultation journey to date

The National Law requires the NMBA to ensure there is wide-ranging consultation on the content of any proposed new standard, code or guideline. It is important to consult with all stakeholders in order to consider the impact of the proposed options and take into consideration the views that stakeholders hold about the proposed options and the impact that the proposal may have on them as individuals or their organisations. Stakeholders can often add value to suggestions around options or provide alternative options through consultation that have not been considered. It is essential that the suggestions and feedback are captured as it is likely to lead to better outcomes and understanding of the options proposed.

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

- 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.
- 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.

In March 2017, the Commonwealth Chief Nursing and Midwifery Officer, Australian Government, Department of Health held a national symposium to explore the potential for RN prescribing. An outcome of the symposium was the overarching support to adopt a health professional prescribing pathway that would see appropriately trained and educated RNs prescribe within their scope of practice, under designation or supervision of an authorised health practitioner. A subsequent NMBA discussion paper led to the development of the the proposed registration standard.

The proposed registration standard has been widely consulted on with preliminary consultation occurring in April 2018, public consultation in July 2019 and finally profession-specific consultation in March 2019. The feedback from all rounds of consultation (summary provided at [Appendix C](#)) informed the development of the proposed registration standard and associated guidelines Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber.

As a part of this consultation 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 designated RN prescribers can assist in addressing these issues and provide increased benefits to the professional role of the RN workforce. As illustrated throughout the D-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 the health workforce should support extending scopes of practice such as RN designated 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.

In Australia the Government mandates that policy proposals which recommend the introduction of regulation, must be accompanied by an Australian Government Regulation Impact Statement (RIS).⁽⁶⁹⁾ This an economic evaluation where the costs and benefits of a proposed policy action are considered in monetary terms to inform decision-making in the health sector. The RIS assists with determining potential impacts of a new regulation in order to assess whether the regulation is likely to achieve the desired objectives. The process involves extensive analysis of the underlying policy problem, the presentation and impact analysis of at least three viable options, and comprehensive stakeholder consultation. Policy proposals must also quantify the regulatory burden on individuals, businesses, and community organisations under the viable options.

As the proposed Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber (registration standard) and associated guidelines have a regulatory impact, the NMBA was required by the Office of Impact Analysis (OIA) within the Australian Government, Department of the Prime Minister and Cabinet to undertake further consultation in the form of a consultation regulation impact statement (C-RIS).

The C-RIS incorporated 26 consultation questions to enable the NMBA to purposively consult with stakeholders to seek further information relating to the costs, benefits and impacts of the options proposed and how the regulatory proposal would work in practice. The OIA noted C-RIS was an evaluative process for the NMBA designed to analyse the impact of the options put forward to guide informed decision-making and finalise its policy position incorporating this feedback and evidence to prepare the to prepare the Decision RIS (D-RIS) for the OIA and potentially recommend that the Ministerial Council for the National Scheme approve a registration standard.

Public consultation on the C-RIS took place from 16 June 2023 to 11 August 2023. The consultation paper was emailed to 41 key stakeholders and published on the NMBA website. Additionally, a link to the consultation was published in the NMBA e-newsletter. Through these various formats, stakeholders, registrants and the public were invited to provide feedback to the consultation.

Qualitative analysis of feedback to the consultation regulation impact statement

Analysis of the feedback received through the C-RIS public consultation process has guided the development on a preferred option for designated RN prescribing. The NMBA received 109 responses to the consultation questions via the online Qualtrics survey and 24 written submissions to the consultation paper. However, it should be noted that not all respondents provided responses to all the consultation questions (both written submissions and Qualtrics survey responses).

It is also important to note that the feedback to the C-RIS did not yield the quantitative results required to strengthen a cost benefit analysis. As such, further interviews and meetings with stakeholders who provided feedback were undertaken to frame scenarios and costing through the Independent Hospital Pricing Authority. These interviews helped to strengthen the costs versus benefits. Further follow up meetings were held with the below organisations and individuals to gain more information on the impacts of designated RN prescribing:

- Representatives of Palliative Care Services – Nurse Practitioner and Policy Manger
- The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) in response to feedback to include additional examples from rural context and those from aboriginal community-controlled contexts
- RN credentialed diabetes educator representatives from Diabetes Australia
- Australian Primary Health Care Nurses Association (APNA)
- NPs working in acute tertiary centres, palliative care and primary care
- RNs working in rural and remote areas across aged care, palliative and community as well as those working in primary care centres and hospital organisations
- Representatives from the emergency care and assessment treatment – Emergency Care Institute project for the NSW Government and Agency for Clinical Innovation, Project Officer and Policy Staff
- Katie Pennington who recently undertook doctoral studies into medicines legislation and its impact on the delivery of healthcare by registered nurses in very remote Australia
- Dr Gigi Lim from the University of Auckland
- Registrar of the Te Kaunihera Tapuhi, Aotearoa, Nursing Council of New Zealand
- Bush Clinic RNs.

The below table outlines the preferred option selected by respondents who provided a written submission to the C-RIS:

Option 1	Option 2	Option 2(a)	Option 2(b)
• 3 agree	• 16 agree	• 1 agree	• 4 agree

Qualitative findings: Problems identified in the C-RIS

Decision regulation impact statement: Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber

The survey and written submission results indicated overwhelmingly that participants agreed with the problems that were identified in the CRIS:

Excerpts from the responses:

“Timely, equitable access to medical care is an increasing issue which could be significantly addressed by enabling suitably educated, qualified, and authorised registered nurses to work to the full extent of their scope in the management of setting specific common, less complex conditions and long-term chronic conditions with this management including clearly defined medication prescribing capability”.

“The Office for one of the state’s health complaints agency agrees that addressing inequities in access to timely, safe, and appropriate quality healthcare in Australia has been long standing and continues to create ongoing challenges. As noted, 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. The agency also agrees that reduced access to quality healthcare contributes to individuals experiencing, in general, poorer health outcomes”.

“A prominent nursing college and its members agreed that the problem statement is identified in the CRIS. The problem statement highlights the disparities many people experience when trying to receive timely, safe, and high-quality healthcare. Strategic solutions are needed to address the problems of providing adequate care for many members of the community, particularly the ageing population with their worsening chronic health issues. Remote and rural areas also encounter more challenges and complex health requirements”.

There were a small number of respondents that did not agree with the problems stating that only medical practitioners should prescribe:

“Registered nurses are not doctors and do not have the education or knowledge to prescribe”.

The NMBA clearly articulated in the C-RIS that RNs are not in any way trying to be doctors, and do not wish to detract from the role of the medical practitioner. However, they do wish to enter into a collaborative agreement for the benefit of the patient and health consumers. RN prescribers choose to undertake postgraduate qualifications to prescribe under the supervision of a medical or nurse practitioner judiciously, appropriately and safely. They cite the reason to do so is for clinical effectiveness in clinical practice and the ability to provide a complete episode of holistic care allowing patient involvement in addition to providing job satisfaction.^{20,88} It is also important to note that research has indicated that non-medical prescribing is equally appropriate to medical prescribing with RNs having no difference to doctors in regards to safe prescribing. Through a trial of non-medical prescribing there were indications that non-medical prescribing may lead to significant reduction in omission and prescribing errors.^{29,71}

Other respondents who agreed with the problem statement did however raise concerns around training requirements:

“Completely agree with the problem statement. The inequality in regional and remote areas have progressively become apparent, especially during the recent years. The availability and accessibility to GPs has resulted in a decline in quality of life or the need to travel to urban areas to receive treatment. It is essential that by identifying and responding to these problems we do not create more problems. Prescribing by RNs must only follow by successful completion of recognized training, not just left to the RN only to determine whether they practice within their scope. Unfortunately, not all RNs understand what that means”.

While there are pathways already in place to allow prescribing arrangements for non-nurse practitioners the current pathways already authorised such as, dispensing and prescribing via structured arrangements or prescribing from protocol, lack nationally consistent regulated requirements where education and credentialing are jurisdictionally dependent and may cause inconsistencies in the medication management role of RNs.^{20,89, 96}

In response to the question, *Are there any additional effects to people accessing healthcare that are caused by the problems or issues outlined in the C-RIS?* The majority of respondents answered ‘no’ and the respondents who answered ‘yes’ importantly included that health consumers could not afford to visit their GPs which reinforced access and equity issues.

Decision regulation impact statement: Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber

One respondent commented:

“The GP shortage has created a financial monopoly where bulk-billing rates have dropped significantly. People therefore cannot afford to go to a GP and present to ED, which creates an onward spiral”.

This anecdote may support the 6.9% increase in presentations to emergency departments during 2020-2021 despite restrictions to healthcare during the COVID-19 pandemic.⁹⁷ There were also steady increases during 2021-2022 demonstrating increased rates of potentially preventable hospital presentations in disadvantaged populations such as people living in low socioeconomic areas, those living in areas outside major cities, and among Indigenous Australians.^{98,99} This was also supported by patient data, with the most commonly cited reasons for not seeing a GP when they felt they needed to, regardless of hospitalisation status, was due to not being able to get an appointment when needed, and also cost.¹⁰⁰

Fragmented care was also cited as a problem by respondents:

“In some case where people receive community care/visits from hospital staff (generally nurses or midwives) they are then required to go to the hospital to get a prescription or pick up medication. A prescription issued by the person visiting would enable them to use local services”.

Respondents identified mental health and diabetes as areas that could greatly benefit from the likely improved access to care with the introduction of designated RN prescribing as well as those patients seeking fertility treatment which was one group of patients and staff overlooked in the initial C-RIS:

These responses to the consultation are not unlike the journeys of the patients described by RNs which included the patient’s inability to access care and the inability of RNs to work to top of scope and provide a complete episode of care when often they are often already working through the full medication management cycles in areas where they have long held prescribing responsibilities.⁹⁶ It is also important to note that chronic conditions are a significant health issue and a leading cause of death in Australia. The Australian Health system spent an estimated \$3.1 billion in diabetes between 2019-2020 and between 2017-2019 diabetes complications were one of the leading causes of hospitalisations in Aboriginal People which could have been treated in a non-hospital setting through timely and effective care and

“From a diabetes educator perspective, people living in rural or remote communities often do not have MO access but frequently have RN access. The current diabetes framework is to teach people to self-manage their diabetes. There is no scope to commence a person on insulin or oral medications when indicated. Pathology results may indicate the need to cease a medication such as Metformin as the continuation could cause adverse outcomes/complications. The longer the person has BGL readings out of target range the increased risk of complications associated with diabetes. e.g. nephropathy, retinopathy, neuropathy. Quality of life is impacted, cost to health service increased resulting in the need for amputations, or dialysis. Diabetes is the leading cause of blindness in Australian adults. The leading disease resulting in dialysis is poorly controlled diabetes. This may not be provided in remote areas so people have to move to larger centres fragmenting families, increasing stress and isolation, different cultural expectations. These are all preventable with timely intervention. Credentialed Diabetic Educator (CDE) RNs have the authority to commence people on continuous glucose monitoring (CGM) but not medications”.

“I respond to incident reports for rural/remote areas - once of the effects of reduced access impacts on mental health clients who require clozapine. This medication has to be carefully managed, and if it is stopped for more than 48 hours, it must be re-titrated, resuming it is at the previous dose may cause serious adverse events including cardiac arrest. I’ve had several reports of MH consumers being unable to access a GP for the required routine review for weeks. Additionally, a COVID diagnosis also limits their ability to access their GP”.

“I work in the fertility treatment and find that patients anxiety levels are regularly exacerbated by being unable to access their specialist to gain medications that require top ups for ongoing treatment. This creates further difficulties in an already stressful journey. To be able to utilise endorsed RNs in this setting would be a game changer for patient care”.

“In rural aged care facilities, the GP may only visit monthly. Any changes that need to be made to the prescription because for example the GP has made a prescribing error - or the electronic prescribing system limits the ability of nurses to amend prescription (perhaps because a transdermal patch prescribed every 7 days fell off at day 4) currently cause a delay in appropriate medication management”.

management^{48,99,101} with designated RN prescribers involved in collaborative health management and treatment plans.

Qualitative findings: Additional problems that respondents identified were not in the C-RIS

“The requirement for nurses to have 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 would exclude a lot of senior and capable nurses that have moved away from clinical work seeking new challenges. This model would not encourage those senior nurses to return to the clinical workforce. The APNA workforce survey found that most nurses in general practice have at least 20 years of experience as a registered nurse and 11 years of this completed in primary care however many may not be working full time and may have had time away from the workforce for pregnancy or other carer duties”.

The NMBA set the above requirement to ensure that RNs seeking this endorsement have recent clinical experience. This requirement aligns with the both the NMBA *Registration standard: Endorsement for scheduled medicines for midwives* and the *Registration standard: Endorsement as a nurse practitioner*, and in the view of the NMBA contributes to ensuring RNs who are seeking to prescribe scheduled medicines are safe and competent to practice.

Qualitative Findings – Costs of Option 1: maintaining the status quo

Participants responded overwhelmingly that there would be no benefit in maintaining the status quo:

Excerpts from the responses:

“There are no benefits in maintaining the status quo. The costs will result in primary care failing to attract nurse graduates. Over a third of primary care nurses plan to leave primary care in the next 2-5 years. Failing to replace this workforce will result in further reductions in access to care. Increasing the scope of practice of nurses in primary care would improve nurses’ morale and is likely to result in staff retention and would provide an exciting career pathway for graduate nurses. Additionally, the GP workforce is shrinking, and medical students are not choosing general practice as a career pathway. Most practice advertisements for new GPs promote nurses as a benefit of working at that practice. Attracting nurses to primary care could also help in the recruitment and retention of GPs”.

“The current status quo is not sustainable and will continue to deplete quality care”.

“I don’t think maintaining the status quo is in the best interest of the Australian population health. It would limit the achievement of key strategic health plans and persist the current inequity in access to simple health care”.

“I fully agree that maintaining the status quo will not address the problems of access to health care across a range of populations. This will also not improve career prospects /job satisfaction for RNs and will potentially exacerbate workforce issues. This will continue to increase the pressure on the GP workforce and increasingly interfere with the provision of comprehensive care for people with complex and chronic conditions”.

Additionally, respondents stated:

“Lack of equity and access for Australians will remain if we do not utilise the largest healthcare workforce to work to full extent. Endorse and extend scope of practice so we can meet the demand for services from an ageing and complex population. The post code lottery will remain with status quo which means poorer outcomes for those people that cannot access services. This is too large a cost”.

and there would be:

“RN dissatisfaction RE: expanded scope of practice. RNs should be able to prescribe Over the counter OTC (schedule 2&3) medicines without restriction now. This already forms part of undergrad nurse training, and most RNs will deal with these daily and will be comfortable and familiar with those drugs”.

It is important to note that undergraduate Bachelor of Nursing (BON) education accreditation standards that lead to graduates being able to apply for registration as RNs have curricula content that includes the Quality Use of Medicines Framework and students must meet the learning outcomes and demonstrate skills and knowledge in pharmacotherapeutics and Quality use of Medicines Framework. Additionally, to undertake the postgraduate qualification that leads to an RN being able to apply for the Endorsement, RNs would need to undertake an Australian Nursing and Midwifery Accreditation Council (ANMAC) accredited postgraduate qualification for RN designated prescribing and on application for the endorsement must be able to demonstrate current registration and three years post initial registration clinical experience within the past six years. It is also likely that these RN’s already have advanced clinical experience, expertise, knowledge, skills and attributes in their specific areas of practice – which may include formal postgraduate qualifications relevant to the area in which the RN already practises.

Some of the respondents noted that:

“There would confusion for patients, clarity on role delineation, not dumping another complex role on to nurses who are already overworked and burnt out!”.

It is important to acknowledge that midwives with an endorsement for scheduled medicines, whilst contributing a significant change to the regulation of midwifery, reported that lack of public

awareness of their role was a barrier that could be enhanced through increased community awareness about their scope of practice to prevent role confusion. They recommended raising awareness of the endorsed midwife role across health consumers and health care providers.¹⁰² The NMBA intends to include this feedback in their implementation plan if designated prescribing is agreed.

“High quality safe prescribing”, was one of the benefits reported in the survey and this supports findings in the literature that RNs prescribe in comparable ways to medical practitioners and the effects of nurse prescribing are similar if not better in comparison.

It is important to point out that whilst designated prescribing can potentially improve access and equity to medicines and improve healthcare efficiency, RNs would be more than just RN prescribers. They maintain role preservation as an RN and designated prescribing would be an included element in their nursing practice if it was required in the overall plan of care for their patients.^{27,86}

A prominent Physicians College responded that they preferred that the status quo be maintained and cited “that a visit to the GP was not just a about a prescription”. As discussed, this is also not the intention of the designated RN prescribing role, as above this would be an element of the RN role in an episode of collaborative and integrated care that further improves access and equity. A report undertaken by Price Waterhouse Cooper Consulting in July 2020 on behalf of the college noted the vision for general practice was a sustainable healthcare system, economically this included a proposed \$773 million dollar savings on preventable hospitalisations, hospital readmissions and emergency department presentations. Designated RN prescribing could contribute to this and in addition contribute collaboratively to the college’s vision “to improve the health of the population, improve the patient experience of care, reduce healthcare costs and improve the work life of health providers.”¹⁰³

The college support that the nurse practitioner role should be maximised, and NP and GP distribution across Australia could be improved. However, NPs have noted that the role of the designated RN prescriber “would provide an opportunity for NPs to support professional development pathways and succession planning”⁸⁹ which could further assist in the distribution of NPs if designated RN prescribing was a pathway.

The NMBA notes the concerns of the medical profession and the risks they perceive to be associated with non-medical prescribing such as antimicrobial resistance in prescribing, prescribing that needs to be carefully targeted and calibrated, monitoring of ongoing use of medications, fragmented care and increases in the volume of prescribing. There is however sufficient evidence internationally to support the introduction of designated RN prescribing in Australia. International studies demonstrate it has been embedded successfully in multiple countries with comparative and non-comparative health care systems. The evidence also supports that prescribing by RNs can be as appropriate and safe compared to medical prescribers. The potential benefits of designated RN prescribing far outweigh the anecdotal concerns and can lead to improved patient access, equity to healthcare and improved management and treatment through collaborative interprofessional healthcare models. These models allow for those RN’s who choose to work to the top of their scope in providing complete episodes of care.

Additionally, a Primary Care Nursing Association in its response to the consultation:

“Supports the expansion of the model of prescribing for experienced registered nurses to prescribe scheduled medicines in partnership with a registered prescriber. Allowing appropriately trained and supported nurses to prescribe within their scope of practice in primary health care settings is likely to reduce the pressure on Australia’s health care system and increase timely access to care and medications”.

This could further support areas where there is inadequate distribution of GPs and NPs enhancing innovative care models across primary care.

Further respondents’ feedback:

“May reduce GP burnout and help retain practitioners”.

“Would promote peer networking and provide sole GPs with a second person with whom to discuss medication issues”.

There was also opposition from a Doctors Association who would prefer to maintain the status quo that cited the lack of a rigorous cost-benefit analysis. This association is correct in that only a hypothetical cost benefit analysis has been undertaken with the C-RIS failing to gather any sufficient data to add value to a cost benefit analysis. However, as stated throughout the document this issue is not specific to this initiative and there is worldwide limited evidence on the costs and cost effectiveness on non-medical prescribing ^{71,72} in favour of studies that increase equity and access to healthcare. Costs related to an increased number of prescriptions cannot be denoted as implementation has not occurred, however there could be potential for this to be evaluated and assessed in the future.

A Post Graduate Diploma that offers the Designated RN Prescribing course will need to be approved by the Australian Nursing and Midwifery Council (ANMAC) and approved by the NMBA. Currently, in rural and remote areas it is up to individual healthcare organisations and the RNs themselves to ensure that they have the knowledge and skills to fulfil medication management responsibilities in relation to the in the Quality Use of Medicines Framework. This opportunity offers a standardised approach to education and training. ⁹⁶ Furthermore, contrary to the feedback regarding an increased risk of incorrect prescribing, studies report that non-medical prescribing may in fact lead to less prescribing errors and a reduction in omissions, with non-medical and medical prescribers being equally appropriate and comparable. ^{30,48,64,65}

Another medical stakeholder was also not supportive of RN prescribing however would be prepared to consider specific models of RN prescribing of Schedule 2,3 and 4 medicines (option 2a) pending that this was within a medically led and delegated team environment with agreements in place. The association also provided feedback that pilot studies would be beneficial to ensure that the model is safe and effective within the Australian context.

Qualitative findings: Additional costs and benefits not included in the status quo

There were no additional explicit costs and benefits communicated however it was reported that:

“Individual costs to consumers not able to access timely health care. Costs for consumers needing to take time off work to travel to urban areas to access healthcare. Physical costs for consumers that delay traveling to access health care in urban areas can lead to poor health outcomes and greater dependence on health care and aged care”.

The NMBA acknowledge this is difficult to quantify benefits individually overall however it is anticipated that the implementation of designated RN prescribing will improve access to healthcare, reduce time and costs associated with travel to access healthcare.

Qualitative findings: 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.

The C-RIS feedback provided further qualitative value in terms of barriers and enablers. Feedback did not add value or provide the level of detailed required on actual quantitative costs and benefits, or the potential costs and benefits, outlined by the Office of Impact Assessment (OIA) to inform the development of the decision: regulation impact statement (D-RIS). Instead, these have been described through various patient journey scenarios presented above that outline hypothetical costs related to the journey.

There was overwhelming support for option 2, that RNs expand the scope of practice to prescribe 2, 3, 4 and 8 medicines under supervision as this would improve access to healthcare for consumers.

Respondents in support reported that:

“Consumers will be able to access a wider range of people when they require prescriptions. If they already see a nurse on a regular basis, they will benefit from fewer medical appointments just to renew prescriptions. Many members of marginalised communities already have a relationship/ receive care from nurses - this will allow them to access more of their care from a trusted individual”.

“Increased Access to Healthcare, Nurse prescribing can help address shortages of primary care providers, especially in rural and underserved areas. It expands the workforce capable of providing essential healthcare services, making it easier for patients to receive timely treatment”.

“Streamlined Patient Care, Nurse prescribing can lead to more efficient and timely patient care. Instead of waiting for a physician's approval, nurses can prescribe medications promptly, reducing delays in treatment and improving patient satisfaction”.

“Improved Chronic Disease Management, Nurse prescribers can play a crucial role in managing chronic conditions, such as diabetes or hypertension. They can adjust medications as needed, monitor patients closely, and provide education on medication adherence and lifestyle changes”.

“Collaborative Practice, Nurse prescribing operates within a framework of collaborative practice with physicians and other healthcare professionals. This ensures that prescribing decisions are made in consultation with the patient's primary care provider, promoting safety and accountability”.

“Cost-Effective Care, Nurse prescribing can potentially lead to cost savings in healthcare systems. Nurses may prescribe generic medications and focus on preventive care, leading to reduced healthcare expenditures over time”.

“Improved Patient Education, Nurses are skilled educators who can provide patients with essential information about their medications, potential side effects, and how to take them properly. This can enhance patient compliance and safety”.

“Patients will have timely access to titration of medications and reduce emergency admissions”

“More healthcare providers can reduce wait times and decreased delays in waiting times for GP's”

“Consumers will be able to access a wider range of people when they require prescriptions. If they already see a nurse on a regular basis they will benefit from fewer medical appointments just to renew prescriptions. Many members of marginalised communities already have a relationship / receive care from nurses - this will allow them to access more of their care from a trusted individual”.

“Benefit of option 2 would outweigh costs as it would provide minimal disruptions to patient care if patients were only awaiting a script for specific medication. Also beneficial for both inpatients and patients in the community awaiting to see GP just for scripts. Strict governance however would be required”

Respondents also raised concerns around:

“No specific education about pharmacokinetics”.

“Over-prescribing”.

“Concerns regarding opioid prescriptions outside palliative care settings. Potential for misuse / overdose”.

“Just keep prescribing” is a dangerous and costly approach to care. Medications need to be under constant review for appropriateness - the proposed model seems to promote “just keep prescribing”.

“Less qualified practitioners prescribing without complex patient assessment”.

Postgraduate qualification in RN Prescribing education will include pharmacokinetics and pharmacotherapeutics and build on the foundations of accredited Bachelor of Nursing Programs and Quality use of medicine frameworks. Assessment and competence in pharmacotherapeutics will include the assessment and appraisal of competence in pharmacotherapeutics. It is anticipated that select units currently offered in the Masters of Nurse Practitioner will be modified for use in postgraduate studies. Accredited NP courses already have established and embedded educational principles and pedagogical approaches to achieve the learning outcomes required for designated RN prescribing and will allow for potential articulation pathways to the NP course. The program of study is delivered at an Australian Qualifications Framework Level 8.

The NMBA is working closely with ANMAC and is part of the ANMAC RN Prescribing Accreditation Standards Project Working Group who have undertaken an extensive gap analysis between the *NPS: Prescribing Competency Framework, Registered Nurse Accreditation Standards 2019*, NMBA's *Registered nurse standards for practice 2016* and the *National Safety & Quality Health Service Standards (NSQHC)*. There has been a comparative analysis with national and international pedagogical frameworks and standards for non-medical prescribing to assist in the delivery of ANMAC Designated RN Prescribing Accreditation Standards for Programs Leading to Endorsement for Scheduled Medicines for Registered Nurses. Public consultation has occurred on these standards and they are near finalisation.

Additional risks were highlighted by respondents regarding:

“Risk of medication error but this exists with all prescribers currently”.

“Inappropriate prescribing without full consideration of all relevant factors”.

“Risk of medication error but this exists with all prescribers currently”.

“Harm to consumers is not adequately covered. Indirect costs of attempting to take over medical practitioner's role in the health sector through mission and scope creep of nursing only creates further divide amongst the professions”.

There is evidence to suggest that whilst medication administration by RNs is not error free, RNs contribute significantly to the safe use of medicines which is underpinned by clinical reasoning, contextual practice, and situational practices.⁹⁶ Australia has a well-developed medication error reporting culture in nursing and openly encourages incident reporting which includes near misses of medicines and potential medicine hazards. Encouraging medicine related risk reporting is key in establishing a culture of safety. The practice of bedside handover with the patient present to include medication discussion and medication reconciliation to ensure that what the patient is prescribed matches the medicines that are prescribed, rights of medication, double checking medicine charts and electronic medical record charts for omissions and shared interprofessional decision-making behaviours with the patient at the centre of care ensure safety in medicine management. This concurs with studies that find appropriately trained RNs fare no differently where safety related to nurse prescribing is concerned.^{30,70,71,87,88,89} There was no difference in the number or types of medications prescribed per patient between non-medical and medical prescribers.

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In a collaborative study regarding prescribing of scheduled medicines, it was found that RNs and midwives prescribed mostly Schedule 4 medications, anti-infectives followed by analgesics, however this study did not detail the class schedules of the analgesics.⁸⁸

There are currently 1,098 midwives with an endorsement for scheduled medicines practising in Australia. These endorsed midwives are able to prescribe Schedule 2, 3, 4 and 8 medications and to date there have been no notifications regarding misuse, overprescribing, inappropriate prescribing, risk or harm. Antimicrobial selection by RNs has also been found to be more appropriate than medical practitioners in a QLD single study that used an audit tool to examine safety and efficacy in subscribing for supply.^{104,105}

There were some challenges identified by respondents that the C-RIS did not include such as:

“Other costs to the practice include backfill for nurses undertaking prescriber studies and cover with an additional nurse while the prospective nurse prescriber completes the three-month mentoring program. It is likely that the costs for the study course, travel time, and time to attend the course will be borne by the practice nurse. It is likely that the costs for the study course, travel time, and time to attend the course will be borne by the practice nurse”.

The NMBA acknowledge that some backfill may be required if the RN undertaking postgraduate qualifications decides to take study leave, however courses are designed in a hybrid model so that postgraduate students are able to study and work simultaneously. Designated RN prescribers would not be required to undertake leave to be mentored as this would be undertaken through work integrated learning (WIL).

A 2016 Australian study noted that there were no Commonwealth supported placements for nurses undertaking postgraduate study in primary care which would assist with the financial burden of study. It also noted that more flexible modes of course delivery should be made available to nurses who work and reside rurally or remotely as these factors could influence nurses to undertake study and build capacity in these areas of need in primary health care and general practice.¹⁰⁵

An increase in Commonwealth supported placements offered in university courses that offer postgraduate studies in designated RN prescribing may increase uptake in courses that lead RNs to apply for the endorsement. This may incentivise RNs to articulate to the NP role through established pathways and through experience gained from the designated RN prescriber role.

Time costs to implement a governance framework were a concern for some of the respondents and the requirements to organise prescribing agreements with each health service as well as ongoing costs for review, audit, and evaluation. Respondents noted that:

“If these costs are prohibitive, this will negatively impact small practices in the rural and remote areas that most need increased access to care”.

There will be time costs to implement the structure as per respondents’ feedback however the benefits outweigh the costs and innovative frameworks developed across healthcare facilities could assist with timing and direction. A collaborative model-based approach using specific outcome measures that also assist in understanding how best to implement designated RN prescribing across various healthcare organisations and allow for collaborative comparisons for those who choose to embed the designated RN prescriber role will also be beneficial.

As outlined previously, there is a lack of data related to costs in the implementation of non-medical prescribing in favour of studies comparing the effectiveness and safety between non-medical and medical prescribing. This was also evident in the 2018 KPMG report on *Cost Benefit Analysis of Nurse Practitioner Models of Care*⁸⁶ which used case scenarios to examine relative costs.

A recent systematic review found factors influencing the successful implementation of non-medical prescribing were fund provision, organisational plans and strategic government inclusion which acted as core motivators for successful implementation.¹⁰⁶ State and territory pilot studies have been previously undertaken for the NP role with the expanded role for community pharmacists.¹⁰³ Similar studies would be beneficial for the implementation of the designated RN prescriber.

Some of the further barriers identified to implementing designated RN prescribing reported by respondents were:

“Barrier to nurse prescribing linked to being able to access medical practitioners - this will likely mean ongoing barriers/delays”.

“The supervision agreement must allow for indirect supervision. If the responsible prescriber needs to be on the same premises as the designated nurse prescriber new models of care such as outreach or in-home care will not be developed”.

“In order for RN prescribing to be financially viable, RN prescribers will need to have access to MBS and PBS – cost to implement and administer this process”.

“As noted, if RN prescribing is not subsidised via the PBS, there may be significant costs to the consumer. As many of the patient populations expected to benefit from RN prescribing are disadvantaged, this is a considerable concern. Efforts to ensure PBS subsidies for RN prescribing should be included in this plan’.

Endorsed midwives also reported that there were PBS limitations and some medicines prescribed from a limited list were not an approved item on the PBS. These medicines were at full cost to the patient who felt financially penalised.¹⁰² This defeats the purpose of endorsed midwives being able to provide a complete episode of care and if women cannot afford the cost, it may also lead to fragmented care. Throughout our consultation, we have spoken about the PBS requirements for designated RN prescribers to the Commonwealth Chief Nursing and Midwifery Officer and the Chief Nursing and Midwifery Officers for each state and territory. Discussions were also had with representatives from the Australian Government Department of Health and Aged Care around economic modelling. PBS for designated RN prescribers allows for tracking of medications which can assist in evaluation in Quality use of Medicines. PBS for designated prescribers will be required for RN designated prescribers outside of public hospitals for the model to be effective.

Qualitative findings: Additional options not included in the C-RIS

The following responses provided alternative options to those not included in the CRIS:

“Establishing more Nurse Practitioner led models of care that incorporate screening and diagnostic skills in addition to prescribing may be beneficial. A focus on increasing the total nursing workforce and expanding Nurse Practitioner models of care while maintaining the status quo of the nursing role may lead to similar health care improvements to those proposed in the paper. Another option might be to expand the proposed prescribing role in collaboration with other health practitioner boards to promote access to healthcare delivered by clinicians of many disciplines, particularly in primary health care settings. National Boards could work together to introduce a core Registration Standards Endorsement for Scheduled Medicines that could flexibly relate to any health discipline including nurses and midwives. This would share the prescribing workload across health professions and to specific professions educationally prepared to prescribe medication. This may support ongoing access to care by minimising potential workforce impacts, regardless of which discipline is a person’s primary care provider”.

The NMBA acknowledge this feedback. Prescribing by other health professionals is outside of the regulatory remit of the NMBA. The NP role was promoted as a health reform strategy to reduce pressure on the health care system, address workforce shortages and improve rural and remote populations' access to health care services, however in 2021 the government acknowledged the lack of a national strategic plan to set a clear direction for the optimal use of the NP workforce. There has been a failing to realise their full value to the Australian community. Additionally, the evolution of the NP roles has been across specialised areas of practice, with the majority of NPs working in acute sectors of hospitals located in urban areas rather than in the underserved, rural and remote primary health care sector.¹⁰⁷ As of 2022, there were 2,397 NPs registered in Australia. 1,633 of these NPs were predominantly situated in Metropolitan areas. Of the 2,397 NPs registered in Australia, 253 were located regionally, 93 in small rural towns and 46 in very remote communities. In comparison there are 263,931 RNs in metropolitan areas, 37,042 located regionally, 3,870 in small rural towns and 2,496 in very remote communities. are also 1,299 endorsed rural and isolated practice nurses across Australia who have expertise in their specific

contexts of practice. ¹⁰⁸ Expanding the NP role can be achieved through designated RN prescribing. If these RNs choose to undertake postgraduate qualifications for endorsement to become designated nurse prescribers across these areas, the potential for access and equity in healthcare increases, as does their ability to transition to the NP workforce. A RN clinician that worked in rural aged care who consulted on the feedback on the CRIS stated the designated RN prescriber would be a great opportunity to gain experience and then articulate to further NP studies. The role of the designated RN prescriber in low NP populated areas could incentivise RNs to follow pathways that build the nurse practitioner workforce and better integrate the role across areas of need.

Summary of option 2 after consultation and further follow up with participants to clarify feedback:

Benefits
Better coordination of care, especially for populations with chronic disease management.
Increased patient/consumer satisfaction with timely access
Reduced emergency department presentations and improve flow with RNs (education and training prepared) within the partnership agreement being able to prescribe and administer medications within their scope
Pathway for RNs to progress to NP qualification facilitating career progression

Costs
Time costs to implement the governance framework and to organise prescribing agreements for each health service with RN prescribers as well as ongoing costs for review, audit and evaluation. If these costs are prohibitive, this will negatively impact small practices in the rural and remote areas that most need increased access to care.
Potential increase for professional indemnity insurance
Increased salary for RN prescriber
Cost to change to drugs and poisons legislation in relevant states and territories
In order for RN prescribing to be financially viable, RN prescribers will need to have access to MBS and PBS – cost to implement and administer this process.

Qualitative findings: Impacts to current prescribers

On the impacts to current prescriber’s respondents provided the below feedback:

Decreased demand and pressure on GP services:

“On GPs - reduce the need for people with stable conditions who simply require repeat prescriptions - for thyroxine for example”.

Time cost to establish mentoring and prescribing partnerships:

“Significant increase in workload by having to have oversight of someone else's prescribing”.

Reduced GP burnout and practitioner retention:

“Positive impact of first line medication management before a GP”

“Positively affect Increased Access to Healthcare”.

“Decrease burden of practicing outside of hours”.

“Less repeat GP visits for scrips alone”.

Promote peer networking and provide sole GPs with a second person with whom to discuss medication issues.

“Ability for practitioners to work in partnership”.

“Once partnerships are established potential time savings through the shared care of the patient/client.”

Once partnerships are established potential time savings through the shared care of the patient/client.

There are currently no studies that explore the impacts of non-medical prescribing on current medical prescribers or NP’s. Studies have instead focused on the effectiveness across prescribing, differences and similarities in prescribing and enablers and barriers for non-medical prescribers to prescribe. This could be included in future evaluation studies.

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

There was little overall additional evidence in response to option 2 for option 2a. The majority of respondents did not agree with option 2a citing that this would create fragmented care for health consumers. The following respondent’s feedback summarised this sentiment:

“Another invisible and neglected group are those requiring palliative care. When discharged from the hospital to home at the weekend, it can be impossible to organise services to provide adequate pain relief. This results in multiple traumas for the family and a painful death for the person. (1) High-quality community-based palliative care can be delivered well by primary care nurses in regional and remote locations. (2) High-quality palliative care necessitates access to medication to relieve distressing symptoms at the end of life. Some of these medications are S8. It is strongly recommended that consideration be given to aligning RN prescribing to nurse-led models of care that aim to provide palliative care in people’s homes (including residential care environments) and avoid the need to unnecessarily transfer people who are dying to hospital/ emergency departments. The pandemic saw us unprepared; the skills of nurses could have been better utilised if they were already prescribers and practising at the top of their scope”.

The respondent did provide a reference for the feedback.

1. Reed., K. (2020) Sustainable access to appropriate opioids for palliative care patients in Australia-preventing the need for crisis management. *Journal of Pain & Palliative Care Pharmacotherapy*, 34(1), 13-21. <https://discovery.ebsco.com/linkprocessor/plink?id=59e782de-e3c8-35f1-9b7c-1000baec6ce4>

2. Bakitas M, Allen, Watts, K.A., Malone, E., Dionne-Odom, J.N., McCammon, S., Taylor, R., Tucker, R., Elk, R. (2020). Forging a New Frontier: Providing Palliative Care to People with Cancer in Rural and Remote Areas. *Journal of Clinical Oncology*, 38(9), 963–73. <https://discovery.ebsco.com/linkprocessor/plink?id=1819f6dc-68f0-37b4-8ede-786382c68b48>

There was respondent feedback that if option 2a was chosen this would be beneficial for RN's who are credentialed diabetic educators:

“Beneficial for patients living with diabetes- continuous care, well-educated CDE's having an intimate understanding of insulin dosing”.

Overall, the option for 2a summary was that this option would further disadvantage consumers who would still have to seek out a medical professional to prescribe schedule 8 medications. This could also create risk if there were multiple prescribers for the one patient further increasing cost, timeliness, and complexity in accessing care. It is also important to note here that pain is the most common symptom that patients present with to the emergency department worldwide ¹⁰⁹ and palliative care patients and those patients residing in residential aged care should have the option to receive analgesia in a timely manner.

Qualitative findings: 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

There was some support for option 2b however whilst this option aimed to address the risk posed where designated providers are working in isolation, feedback from respondents was that this option would disincentivise RNs in private practice from working in these areas. Those RN s who did engage in private practice would be prevented from growing their business and additionally this would not improve access to timely care.

6. What is the best option from those you have considered and how will it be implemented?

The preferred option, Option 2 – RNs expand their scope of practice to prescribe Schedule 2, 3, 4 and 8 medicines under supervision is the NMBA's preferred option and is supported by the majority of respondents to the C-RIS. This option was also widely supported in the response to the previous public consultation on the proposed registration standard in 2018.

The preferred option would meet the Government objectives under the following initiatives that have been outlined through the DRIS to improve timely and quality access to medicines for all Australians.

- National Health Care Agreement 2022,
- The Stronger Rural Health Strategy,
- The Future Focused Health Care Plan
- Australia's National Medicines Policy would not be met
- Royal Commission into the Aged Care Quality and Safety recommendations
- National Agreement of Closing the Gap
- National Health Act
- Declaration of Alma Ata
- Sustainable Development Goals

Additionally, this option would align with recommendations from the independent Kruk review and the Unleashing the Potential of our Health Workforce Issues paper one and two. Overall, it was concluded through local and international literature reviews, surveys and analysis with health practitioners that Designated RN Nurse Prescribers are timely, safe and effective and ultimately improve the quality of patient care working collaboratively with Medical and Nurse Practitioners.

It was also demonstrated through scenarios and costing that models of care using a designated RN prescriber could decrease pressure points in hospitals, assist with ageing population and chronic disease treatment and management and have far reaching advantages for those patients in rural and remote areas who are disadvantaged through health underservice.

The other options, Option 1, Maintaining the status quo, option 2a, Enabling RNs to expand their scope of practice to prescribe Schedule 2, 3, and 4 medicines and option 2b Enabling 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 have been put forward however both of these have been examined in 3.1, 3.2 and 3.4 of the DRIS and analysis supports that these options would not lead to safe, quality, or timely care that would benefit health consumers or the healthcare system.

Implementation

The NMBA Designated Prescribing D-RIS is subject to review by the Ahpra Scheduled Medicines Expert Committee. The Expert Committees role is to advise on the use of scheduled medicines and the Boards proposal for a new scheduled medicines endorsement. This is consistent with the Australian Health Ministers' Advisory Council (AHMAC) Guidance for National Boards: Applications to the Ministerial Council for approval of endorsements in relation to scheduled medicines under section 14 of the National Law.

Once the review is complete, the NMBA will bring this important matter to Health Minister's attention and advise on the preferred option (option 2). This option allows RN's who are appropriately trained and educated to expand their scope of practice under the supervision of an authorised prescriber with a prescriber agreement in place to judiciously and safely prescribe Schedule 2, 3, 4 and 8 medicines.

As this will be a new policy there will be no transitional arrangements needed to support implementation unless the states and territories decide to abolish structured prescribing agreements for remote areas and replace them with RN designated prescribing. This change would require some transition and education to prevent an access risk, However, if supported, the NMBA will engage in public awareness about the role of the designated RN prescriber in collaboration with commonwealth, state and territory governments, health services and other healthcare organisations. The NMBA look forward to continuing to progress this work with its key stakeholders

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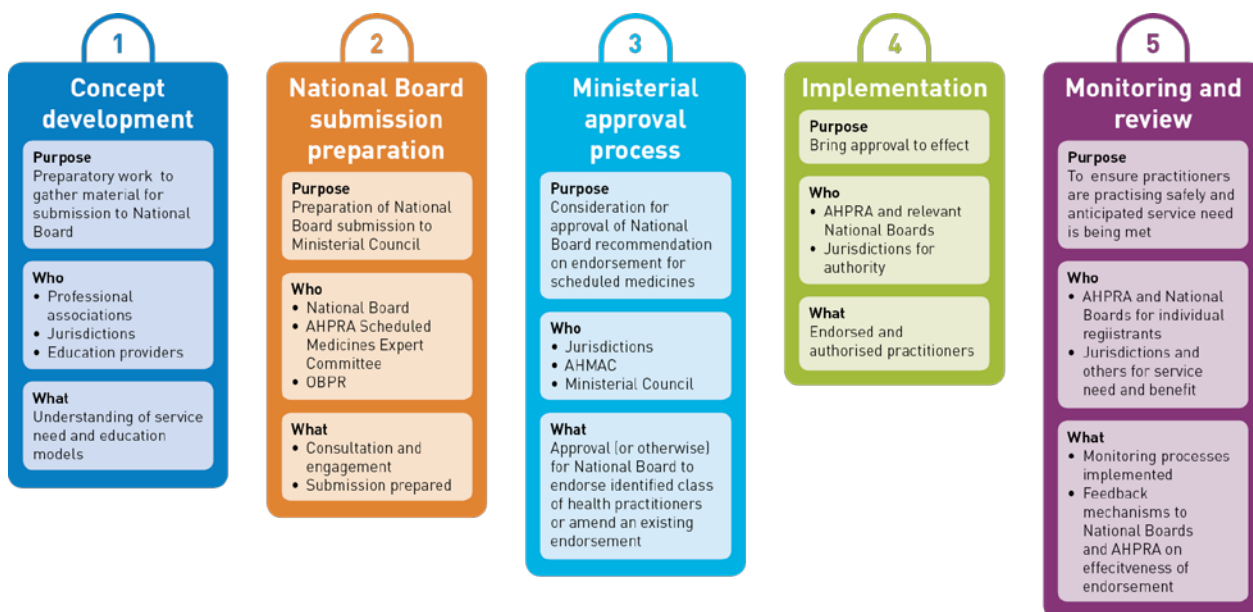


Figure 1: Summary of key stages

The summary of key stages in Figure 1, clearly outlines the outcomes of each stage and the roles of stakeholders in doing the preparatory work to achieve those outcomes.

The Board and AHPRA will take the necessary administrative actions to give effect to the Ministerial Council approval. These actions would include:

- approving new or amended program accreditation standards
- approving changes to qualifications required for endorsement
- establishing administrative arrangements, such as forms to receive and process applications for endorsement
- approving changes to guidelines and or clinical protocols, and
- establishing mechanisms to evaluate the impact of the changed arrangements.

The Board and AHPRA do not have responsibility for:

- giving effect to the approved endorsement by conferring the necessary authorities under legislation
- developing health system requirements such as clinical governance structures, and
- Pharmaceutical Benefits Scheme (PBS) and Medicare Benefits Schedules (MBS)

Following Ministerial Council approval, each minister would endeavour to give effect to the Ministerial Council-approved endorsement and to confer the necessary authorities under state or territory laws. This may require changes to relevant legislation.

The Australian Health Practitioner Regulation Agency (AHPRA), the NMBA and ANMAC are responsible for ensuring registered health practitioners are suitably trained, qualified and safe to practise.

To be endorsed to prescribe, the NMBA will require that designated RN prescribers have:

- Current general registration as an RN in Australia with no conditions or undertakings on 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
- Successful completion of NMBA-approved units of study leading to endorsement for scheduled medicines as a designated RN prescriber
- units of study that are equivalent to the NMBA-approved units of study leading to endorsement for scheduled medicines as a designated RN prescriber
- a period of six months clinical mentorship

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- ongoing competence requirements for prescribing.

Ahpra and the NMBA will work with the Chief Commonwealth Nurse and the Chief Nurses of States and Territories in the implementation phase. There will be widespread communication and strategic communications plans with the Commonwealth Health Department, States and Territories Departments of Health prior to and in the implementation phase. The RN prescribing working group will continue to work to ensure that communications from Ahpra and the NMBA are received by all healthcare professionals, healthcare organisations and the Australian public.

Ahpra and the NMBA have leveraged a key recommendation from a study in 2010 by the National Health Service Trusts (NHS) in the United Kingdom.¹¹⁰ The recommendations and outcomes were to prioritise future action on the importance of non-medical prescribing and include a focus on organisational strategy for non-medical prescribing. Ahpra and the NMBA have kept both the public and all healthcare professions and organisations informed about the progress of designated RN prescribing through their newsletter, forums, social media and website and through widespread consultation in anticipation of this important change.

How Designated RN Prescribing will work in Practice in Australia

This option proposes that suitably educated, qualified and authorised RNs could expand their scope of practice to prescribe scheduled medicines 2, 3, 4 and 8. To give effect to this option in accordance with the National Law, the NMBA would bring forward the proposed Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber (proposed registration standard) to Health Ministers for approval. RNs with this endorsement would be called designated RN prescribers.

This 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 nurse practitioner or medical practitioner.

Nurse practitioners in Australia prescribe autonomously under HPPP Model 1. There are also RNs who initiate listed medications according to standing orders or initiate medications according to specific protocols under HPPP Model 3 – Prescribing via a structured prescribing arrangement. This commonly occurs in emergency departments, areas of practice where there is the absence of a nurse practitioner or medical practitioner and in rural and remote locations. There is no standardisation or nationally consistent regulated requirements for this education, and training and certification varies across jurisdictions as well as between health organisations. ⁽¹⁶⁾

The key focus of the proposed Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber is that it promotes safe, timely and improved access to medicines for communities, and promotes workforce flexibility to meet consumer needs.

In addition to the registration 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 proposed guidelines set out elements that support safe and effective prescribing practices, including the requirement for a prescribing agreement between the designated RN prescriber and authorised health practitioner, that details the scope of prescribing practice and clearly establishes 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 scope of practice and their clinical context in which they are working 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. ⁽³³⁾

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 6-month clinical supervision
- 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/facility, 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

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- 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:

- Current general registration as an RN in Australia with no conditions or undertakings relevant to this endorsement.
- 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.
- Successful completion of:
 1. NMBA-approved units of study leading to endorsement for scheduled medicines as a designated RN prescriber, or
 2. 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 Australian Health Practitioner Regulation Agency (Ahpra), the NMBA and ANMAC are responsible for ensuring registered health practitioners are suitably trained, qualified and safe to practise.

To be endorsed to prescribe, the NMBA will require that designated RN prescribers have:

- Current general registration as an RN in Australia with no conditions or undertakings on 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
- Successful completion of NMBA-approved units of study leading to endorsement for scheduled medicines as a designated RN prescriber
- units of study that are equivalent to the NMBA-approved units of study leading to endorsement for scheduled medicines as a designated RN prescriber
- a period of six months clinical mentorship
- ongoing competence requirements for prescribing.

7. How will you implement and evaluate your chosen option against the success metrics?

There are some challenges that the NMBA may face during the implementation of the proposed Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber which have been outlined in this document. Fortunately, the NMBA has previously successfully introduced the *Registration standard: Endorsement for scheduled medicines for midwives* and there are learnings from the implementation of this that the NMBA can draw upon to ensure the implementation of designated RN prescribing is successful and meets its original aims and objectives. Enablers such as increasing public awareness of the designated RN prescriber role, increasing awareness of the role amongst the health profession and support from health professionals across the health system is required. ⁽⁷⁶⁾

These challenges will extend to jurisdictions and their drugs and poisons legislation that enable designated RN prescribers to be able to prescribe across the states and territories. This is something the NMBA has brought to the attention of Government and the NMBA have recommended this to be included in the scope of practice review. It has also been identified as one of the five themes which emerged as barriers in the *Unleashing the Potential of our Health Workforce – Scope of Practice Review – Issues Paper*. ⁶⁷ Enabling designated RN prescribers to access the PBS is a challenge beyond the regulatory remit of the NMBA however this is a required change by Governments for medicines to be prescribed outside of public hospital organisations. It is important to note that state and territory Health Ministers support an exploration of changes to local drugs and poisons legislation. Designated RN prescribing will not fully achieve the benefits of the recommended option without this support.

What the C-RIS has identified is that internationally and locally there is very little research on the quantifiable costs and cost effectiveness of designated RN prescribing. Future collaborative studies will be required with governments at all levels, health organisation and health consumers to enable quantifiable impacts to improve understanding.

In addition to cost effectiveness discussed in the D-RIS, there would be benefits in undertaking further economic modelling by working with government and organisations to determine the Quality-of-life years gained (QALYS). Undertaking a cost benefit analysis using the Disability of adjusted life years (DALYS) to evaluate the impact of designated RN prescribing would also be beneficial. Additionally, sensitivity analyses such as the value of statistical life years gained (VSLY) could also assist in to quantifying the effects of designated RN prescribing. There has also been research into the use of clinical effectiveness tools from the patient's perspectives such a chronic pain grade, the hospital anxiety and depression scale, satisfaction with and quality of care in the clinical and cost effectiveness of non-medical prescribing. ^(48,49)

The D-RIS is informed by extensive consultation undertaken with both health professions and the public. It has been developed in consultation with the Office of Impact Analysis (OIA), the Australian Government and the Department of the Prime Minister and Cabinet. It describes the objectives, preferred 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 NMBA reviews its standards, codes, and guidelines every five years to ensure that they remain contemporary and are fit for purpose to protect the public and the guidelines. The NMBA can decide to review earlier if the need arises. The registration standard that describes how an RN can qualify for the endorsement for scheduled medicines under section 94 of the National Law and what the NMBA expects of RNs to attain and retail this endorsement will be reviewed at 5 years. Additionally, the endorsement for scheduled medicines for RNs as a designated RN prescriber will be tracked by the NMBA and Ahpra through National Registration Data. Notifications in relation to this area will also be tracked. Part 8 of the National Law sets out the processes by which notifications may be made about a registered health practitioner and the NMBA will follow the Ahpra Regulatory Guide for mandatory notifications. Endorsed midwives who are able to prescribe Schedule 2, 3, 4 and 8 medications have had no notifications made against them regarding misuse, overprescribing, inappropriate prescribing, risk or harm to date.

The NMBA intend to hold consultation and stakeholder open forums as part of its post implementation review of designated RN prescribing and will conduct evaluation via survey.

Australia is lagging behind other countries when it comes to safe and innovative approaches to address healthcare inequities and access. Nurses form the largest component of the healthcare sector and now is the time to act on behalf of all health consumers and Australian citizens and those RNs who wish to work to the top of their scope. This is a timely piece considering the Independent Scope of Practice Review and the themes emerging that support RN Designated Prescribing.

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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)	<p>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.</p> <p>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).</p> <p>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.</p>
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	<p>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.</p> <p>2,218 respondents completed the online survey as individuals while 37 responses were on behalf of an organisation.</p> <p>There was strong overall support for the proposal standard from both the written submissions and online survey responses (87.6% of online survey).</p>
March 2019	Profession-specific consultation: Australian Medical Association (AMA) Royal Australian College of General Practitioners (RACGP)	<p>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.</p> <p>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.</p>

Date	Event	Overview and outcomes
Apr 2019	<p>Stakeholder forum post public consultation</p> <p>Endorsement for scheduled medicines – designated registered nurse prescriber</p>	<p>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.</p> <p>Key stakeholders were informed about the changes to the proposed registration standard and guidelines documents following public consultation feedback.</p>
June 2019	<p>Consideration of proposed registration standard by Ahpra Scheduled Medicines Expert Committee</p> <p>Endorsement for scheduled medicines – designated registered nurse prescriber</p>	<p>The role of the Scheduled Medicines Expert Committee (SMEC) within Ahpra is to advise National Boards on:</p> <p>the use of scheduled medicines generally, and</p> <p>matters relevant to a National Board's proposal for a new scheduled medicines endorsement or an amendment to an existing scheduled medicines endorsement.</p> <p>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.</p>
Jul 2019	<p>Consideration by: Jurisdictional Advisory Committee</p> <p>Endorsement for scheduled medicines – designated registered nurse prescriber</p>	<p>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.</p>
Aug 2019	<p>Consideration by: Scheduled Medicines Subcommittee (HSPC)</p> <p>Endorsement for scheduled medicines – designated registered nurse prescriber</p>	<p>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).</p> <p>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.</p>