Nurse prescribing in New Zealand—the difference in levels of prescribing explained

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ABSTRACT

This article discusses the three types of nurse prescriber currently registered in New Zealand (nurse practitioners, registered nurse prescribers (RNP) in primary health and specialty teams and registered nurse prescribers (RNPCH) in community health). It also provides an overview of the evolution of each group, as well as a summary of the current legislation, prescribing restrictions and models of supervision required for each type of prescriber.

New Zealand has been late in implementing nurse prescribing. Towards the end of the 20th century non-medical prescribing was introduced into many westernised countries, notably in the UK, where nurses have been prescribing for decades.[1,2] The situation regarding the late introduction of nurse prescribing in New Zealand, is a curious one. In 2006, there were only five nurse practitioners prescribing in New Zealand (the only group who were eligible to prescribe at the time), which was in part due to objections raised regarding the safety to the public of these professionals and future nurse prescribers.[3] One commentator at that time highlighted that there were more registered nurse prescribers in the UK than there were doctors registered with New Zealand's General Medical Council.[4] Since then, the numbers and levels of nurses prescribing in New Zealand have substantially increased along with other groups of non-medical prescribers such as pharmacists and optometrists.[2] This article explains the evolution and nomenclature of the different levels of nurse prescribing in New Zealand and the legislation under-pinning each of the three levels (see Tables 1 and 3). Additionally, the prerequisites, education, competencies and registration of the three levels are defined along with the intent of each prescriber's role and the clinical contexts. The discussion will be drawn from current New Zealand legislation as well as professional guidelines published by the Nursing Council of New Zealand (NCNZ), who are the responsible agency for setting educational and professional standards for nurses in New Zealand.

Authorised versus designated prescribers

In order to discuss nurse prescribing it is first necessary to clarify two pertinent terms used in the New Zealand legislation; authorised and designated prescribers. Authorised prescribers may *independently* prescribe, supply, sell, administer or arrange for the administration of any medicine that relates to their area of practice.[1] Current authorised prescribers include nurse practitioners, optometrists, practitioners (dentist or medical practitioner), registered midwives or veterinarians.[1] Designated prescribers, on the other hand, may only prescribe from a list of medicines published in the New Zealand Gazette by the Director-General of Health under section 105(5A) of the Medicines Act.[1] Designated prescribers are also expected to prescribe *collaboratively* alongside an authorised prescriber and have limited permission to diagnose (only minor

Table 1: Legislation pertaining to prescribing.

Legislation	Description
Health Practitioners Competence Assurance Act (2003) (HPCA)[3]	The intent of the HPCA aims to protect the public from harm at the hands of healthcare professionals (HCP). It delegates the responsibility for enacting this to Responsible Agencies (RAs) for each profession. The RA for nursing is the Nursing Council of New Zealand (NCNZ). Under the HPCA, the titles of HCP may only be used by those who have met the standards of and are currently registered with the relevant RA.
Medicines Act 1981[1]	Defines the terms medicine, new medicine, prescription medicine and restricted medicine. Regulates medicines, related products and medical devices in New Zealand. It also outlines the legislative framework for prescribing prescription medicines and the groups of health professionals able to prescribe (includes definitions of authorised and designated prescribers).
Medicines Regulations 1984[4]	Outlines the classification of medicines, and lists the medicines in each category. It also regulates the quality, advertising, labelling, production, transport, prescribing and dispensing conditions, licensing, withdrawal, data sheets and includes schedule of medicines. Section 41 outlines the legal requirements for all prescriptions.
Medicines (Standing Order) Regulations 2002[5]	A Standing Order is a generic prescription that allows non-prescribing health professionals to make drug administration decisions as per prescribed criteria. Authorised prescribers can issue and oversee standing orders, designated prescribers cannot.
Medicines (Standing Order) Amendment Regulations 2016	The above regulations were amended by an Order in Council on 11 July 2016 that allowed nurse practitioners and optometrists to issue Standing Orders.
Medicines (Designated Prescriber: Nurse Practitioners) Regulations 2005[6]	Now revoked and replaced section by the Medicines Amendment Act 2013.[7]
Medicines (Designated Prescriber— Registered Nurses Practising in Diabetes Health) Regulations 2011[8]	Now revoked and covered by The Medicines (Designated Prescriber-Registered Nurses) Regulations 2016.[9]
Medicines Amendment Act 2013[7]	Amends the Medicines Act 1981—added nurse practitioners to the list of authorised practitioners who can prescribe medicines that lie within their scope of practice—giving them equivalence to doctors, dentists and midwives.

Table 1: Legislation pertaining to prescribing (continued).

The Medicines (Designated Prescriber-Registered Nurses) Regulations 2016[9]	The purpose of these regulations is: • to authorise registered nurses who meet specified requirements for qualifications, training and competence to be designated prescribers for the purpose of prescribing specified prescription medicines; and • to provide for the qualifications, training and competence requirements; and • to prohibit registered nurses from prescribing specified prescription medicines if they fail to comply with the requirements; and • to make non-compliance with the requirements an offence.
Misuse of Drugs Act 1975[10]	Legislative framework for controlled drugs.
Misuse of Drugs Regulations 1977[11]	Outlines licensing, permissions, restrictions and prescribing of controlled drugs. Allows designated nurse prescribers (primary and specialty care) to prescribe specified controlled drugs from Schedule 1A. Section 29 sets out requirements for controlled drug prescriptions.
Amendment to the Misuse of Drugs Regulations 2014[12]	Designated prescribers may prescribe from Schedule 1A only. Regulation 29 updated requirements for controlled drug prescriptions to include electronic prescriptions (approved).
Misuse of Drugs Amendment Act 2016[13]	Sets out the circumstances under which patients with addictions may be prescribed controlled drugs (generally only for those working in addition services and after specific application).

Table 2: Examples of contexts suitable for nurse prescribers (not an exhaustive list).

Registered nurse with designated prescribing rights (primary health and specialty teams)[2]	**Registered nurse with designated prescribing right (community health)**[22]	**Nurse practitioner**[23]
Primary care or nurse specialist nurse-led clinics (chronic conditions) • Hypertension • Diabetes • Heart failure • Asthma • COPD • Gout • Eczema • Depression • Anxiety • Palliative care Health promotion • Immunisations • Contraception All must have access to an authorised prescriber in order to prescribe. Other areas may be suitable but the list of medicines that can be prescribed may not be pertinent.	• Public health nurses • School nurses • Community health nurses All must have access to an authorised prescriber in order to prescribe.	NPs can diagnose and prescribe independently so they can work anywhere there is service need for the role.

ailments and illnesses, eg, those that can be confirmed with a simple diagnostic test such as a UTI).[2] Current designated prescribers include pharmacist prescribers, dietitian prescribers and RN prescribers.[1] Table 1 lists all New Zealand legislation that pertains to nurse prescribing in New Zealand.

The following section will discuss each of the three types of nurse prescribers registered in New Zealand [nurse practitioners, registered nurse prescribers (rnp) in primary health and specialty teams and registered nurse prescribers (RNPCH) in community health] and Table 3 summarises the legal and prescribing status of the three types of nurse prescriber in New Zealand.

Nurse practitioners—highest level

In 2001, the first nurse practitioners (NPs) were registered with the Nursing Council of New Zealand (NCNZ), some of whom had limited (designated) prescribing rights.[14] The numbers of NPs were slow to increase over the following decade, due in part to the onerous process to register with NCNZ and the lack of job opportunities following registration.[15, 16] However, in the last few years streamlining the registration process along with increased employment opportunities has led to an increase in the numbers of NP registrations. In 2013, the Medicine Amendment Act listed NPs as authorised prescribers, with near identical prescribing rights to doctors and dentists (See Table 1).[7] Currently there are 465 registered NPs (current on 10 June 2020, figures from NCNZ register).

Nurse practitioners are registered nurses who have been conferred with an additional registration by the NCNZ, following completion of an approved clinical Master's degree. The clinical Master's programme must include bioscience, pharmacology, advanced assessment/diagnostic reasoning and a prescribing practicum (300–500 hours of supervised practice).[17] Under the Health Practitioners Competence Assurance Act, NCNZ is responsible for ensuring that only those who are competent to practice independently are registered as NPs.[1,3] NPs are permitted to diagnose and prescribe independently and autonomously; they can procure, supply and administer medications and prescribe any medicines relevant to their population group.[1,4] NPs work as a sole provider or within a team/service and do not require supervision by a medical practitioner, although supervision by a NP or medical practitioner is recommended in their first year of practice. There are no limitations to the type of presentation or disease that NPs can manage. They are required to undergo regular continuing professional development and participate in self and peer review.[18] Responsibility for ensuring competence and patient safety lies with the individual NP and NCNZ.

The intent of the NP role is to provide high-level expert nursing care combined with diagnostic and treatment skills commonly associated with medical practitioners. As clinical leaders, they influence policy, address inequity by improving access to healthcare for all New Zealanders and role model best practice in patient care.[18]

Registered nurse prescribers (RNP) in primary health and specialty teams—middle level

During 2011, registered nurses (RN) specialising in diabetes care were piloted in four sites around New Zealand following a legislation change that gave them limited authority to prescribe.[8] Evaluation of the project described these nurses as providing safe, high-quality prescribing decisions.[19] A further legislation change in 2016 allowed NCNZ to register RN prescribers working in primary care and other specialty areas who had completed a Post-Graduate Diploma, which included a prescribing practicum (150 hours of supervised prescribing practice by an authorised prescriber). Subsequent to the enaction of this new act in 2016, newly registered RNPs working in diabetes care came under the umbrella term of RNPs in primary health and specialty teams. RNPs are described as designated prescribers and the limitations on their prescribing are summarised in Table 3. RNPs work collaboratively with an authorised prescriber and may only prescribe within that collaborative relationship.[1,2,9] RNPs prescribe for a discreet list of conditions and adhere to a specific list of medicines published by the NCNZ.[20] Some of the medicines on this list have been deemed suitable for continuation prescribing (which differs from a repeat prescription as the patient must be assessed face to face and allows for dose adjustments as required).[20]

Table 3: Comparison of nurse prescribers.

	Registered nurse with designated prescribing rights (primary health and specialty teams)	**Registered nurse with designated prescribing right (community health)**	**Nurse practitioner**
Education	Post-Graduate Diploma (including RN prescribing practicum)	Completion of an approved work-based learning package	Clinical Master's degree in advanced nursing practice (including NP prescribing practicum)
Type of prescriber	**Designated prescriber**	**Designated prescriber**	**Authorised prescriber**
Conditions they can prescribe for?	The specific common and long-term conditions nurses can prescribe for include **diabetes** and related conditions, **hypertension**, **respiratory diseases** including asthma and COPD, anxiety, **depression**, **heart failur**e, **gout**, **palliative care**, **contraception**, **vaccines**, **common skin conditions** and **infections**. Any diagnostic uncertainty must be discussed with or referred to an authorised prescriber.	They may prescribe where the diagnosis has already been made (eg, rheumatic fever secondary prevention), where the diagnosis is relatively uncomplicated (eg, determined through laboratory testing) or for minor ailments or illnesses. Any diagnostic uncertainty must be discussed with or referred to an authorised prescriber.	Able to independently assess, diagnose and prescribe for a **population group or context**. May work autonomously or within a healthcare organisation. Consults with health professional colleagues when relevant. There are **no** limitations to conditions that may be prescribed for. NPs are expected to use their professional and clinical judgement about presentations and patients that are outside their level of knowledge and skillset.
Model of prescribing	**Collaborative prescribing**	**Collaborative prescribing**	**Independent/autonomous prescribing**
What medicines can they prescribe?	May only prescribe from the published medicines list for registered nurse prescribers in primary and specialty care from NCNZ.[20] Some restrictions related to route, form and context have been included in the list.	May only prescribe from the published medicines list for registered nurse prescribers in community health from NCNZ.[24] Some restrictions related to route, form, duration and context have been included in the list.	May prescribe any medicines within their scope of practice, knowledge and competence.
Can they issue repeat prescriptions?	Only after face-to-face assessment (if covered by the medicines list). A small number of medications are deemed suitable for continuation prescribing in the list (where dose adjustments may be necessary) but the RN prescriber must assess the patient face-to-face. These medicines must be initiated by an authorised prescriber.	Only after face-to-face assessment (if covered by the medicines list). Continuation prescribing for Valaciclovir only (but the RN prescriber must assess the patient face-to-face). and this medication must be initiated by an authorised prescriber.	Yes. Provided they have sufficient knowledge about the patient's history and current status to do this safely.
Can they prescribe controlled drugs?	A registered prescriber may prescribe from a limited schedule (1A) of controlled drugs to a patient under their care for a period of seven days ONLY.[11] (Additional prescribing can be granted by NCNZ (upon application) to those working in addition services.)	No	Yes. Same as medical practitioner.

Table 3: Comparison of nurse prescribers (continued).

	Registered nurse with designated prescribing rights (primary health and specialty teams)	Registered nurse with designated prescribing right (community health)	Nurse practitioner
What duration of treatment may be prescribed?	Schedule 1A controlled drugs for seven days.[11] Up to three months' supply of other prescription, restricted medicines, pharmacy-only medicines from the medicines list (unless otherwise stated). Up to six months' supply of an oral contraceptive.[20]	The medicines list for nurse prescribers in community health limits many medications to a single dose or course.	Same as medical practitioner.
Prescribe unapproved medicines?	May only prescribe from the published *Medicines List.*[20] Unapproved medicines are not included in this list. A small number of medicines that are commonly prescribed for unapproved uses have been included in this list.	May only prescribe from the published *Medicines List*.[24] Unapproved medicines are not included in this list.	May prescribe any medicines relevant to their areas of practice. They prescribe within their scope of practice, knowledge and competence.[25] *Currently, section 29 medications cannot be dispensed by a pharmacist unless prescribed by a medical practitioner.*
***ISSUE* Standing Orders?**	Designated prescribers are not permitted to issue standing orders	Designated prescribers are not permitted to issue standing orders	Yes
Able to issue verbal orders for medicines?	No	No	Yes
Order diagnostic tests?	It is expected that RN prescribers are able to order tests that will inform their prescribing.	Yes, limited to their prescribing, eg, wound, throat swabs.	Yes

The intent of the RNP role, is to prescribe within an existing or pre-determined diagnosis, although NCNZ does allow for RNPs to make simple diagnoses such as urinary tract and skin infections.[2] However, RNPs are not expected to demonstrate the same diagnostic skills as medical and nurse practitioners and are required to have oversight from an authorised prescriber who is readily accessible to examine the patient if required.[21] While there is an associated workload for authorised prescribers to supervise RNPs, it is arguably more satisfying than overseeing standing orders. There are clear expectations in terms of governance, audit, ongoing education requirements and peer review for workplaces who employ RNPs.[2] Other restrictions to RNP prescribing are described in Table 3.[2] As of 31 March 2020, there were 59 diabetes nurse prescribers and 213 primary health and speciality teams nurse prescribers registered with NCNZ.

Registered nurse prescribing in community health (RNPCH)—lowest level

In 2019, a third group of nurse prescribers were created; RN prescribers in community health (RNPC). They are also classed as designated prescribers and registered by NCNZ following successful completion of a workplace toolkit.[9,22] The list of medicines they can prescribe from is very limited and the duration of the prescription is for a single dose or course.[24] Like RNPs, RNPCs must work and prescribe collaboratively with and be supervised by authorised prescribers.

The intent of this role is to address inequity in primary care provision and to promote population health by providing access to care and expediting treatment of conditions such as group A streptococcal pharyngitis or impetigo.[22] As with

RNPs, these prescribers are not expected to diagnose anything other than simple ailments. As of 31 March 2020, there were 60 community nurse prescribers registered with nursing council.

To allow further comparisons and clarification, Table 2 summarises some appropriate contexts for each type of prescriber and Table 3 summarises the main differences between the three groups.

Discussion

NPs have the same autonomous diagnosing and prescribing rights as medical practitioners, which allows them to work flexibly and independently in any number of contexts. They can diagnose and treat all first presentations of patients within their knowledge and skillset and do not require medical oversight. In addition, they are expert nurses with the associated knowledge and skills. Despite these attributes NPs still face barriers to employment and restrictions in some practice settings.

Arguably the numbers registered are not commensurate with the needs of the New Zealand population, particularly in primary healthcare.[15] RNPs are well placed to run nurse-led clinics for chronic conditions and some specialty services where the diagnosis is already established and the medicines list they prescribe from is pertinent. Utilising them to see purely first presentations is not impossible but requires RNPs to discuss all but the simplest of cases with an authorised prescriber. RNPCs can prescribe limited medications for simple conditions in uncomplicated patients. Both RNPs and RNCPs require an authorised prescriber to be freely available or to work in tandem with them. The added supervisory burden to the authorised prescriber must be factored into the service delivery model and resourcing. It should also be noted that this model places the accountability for the *diagnosis* of all discussed patients with the supervising authorised prescriber, whereas the prescribing accountability remains with the RN prescriber.

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