RACGP

Royal Australian College *of* General Practitioners

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Nursing and Midwifery Board of Australia
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Via email: nmbafeedback@ahpra.gov.au

Dear Assoc Prof Cusack

RACGP Submission to the Proposed Registration standard: Endorsement for scheduled medicines for registered nurses prescribing in partnership

The Royal Australian College of General Practitioners (RACGP) thanks the Nursing and Midwifery Board of Australia (NMBA) for the opportunity to make a submission on the proposed *Registration standard: Endorsement for scheduled medicines for registered nurses prescribing in partnership.*

Patients and primary healthcare providers have benefited significantly from the contribution nurses make to general practice. Nurses working in primary healthcare settings provide a breadth of opportunities to improve the health of the population through health promotion and illness prevention. Nurses working alongside GPs can increase efficiency and capacity within general practices. The RACGP has, and will continue to, strongly advocate for appropriate support for nurses as part of general practice teams.

1. **Do you agree that suitably qualified and experienced registered nurses should be able to hold an endorsement to prescribe scheduled medicines in partnership with a partner prescriber?**

The RACGP does not support the NMBA's proposal to expand the role of registered nurses (RN) to prescribe medicines through partnership arrangements.

Introducing multiple prescribers is not the solution to addressing challenges in Australia's health system

Multiple prescribers, and the involvement of less qualified prescribers, may risk patient safety.[1] A nurse does not have the comprehensive knowledge of a patient's history nor the appropriate medical training on which to draw in order to provide safe and high quality medical care.

International and Australian experience has repeatedly demonstrated that GP-led multidisciplinary healthcare teams achieve the best health outcomes for patients.[2,3] The RACGP welcomes and encourages other healthcare providers' contribution to providing comprehensive and coordinated patient care. However, the RACGP does not support multiple health professionals offering the same services, as this increases the risk of duplicated services, fragmented care, and wasted valuable health resources.

GPs must remain patients' first point of contact within the healthcare system and retain ultimate oversight of patient care. This allows for comprehensive assessment, diagnosis, initiation of treatment, and referral to appropriately qualified team members (including RNs) in accordance with their qualifications, areas of clinical expertise and levels of support. Patient safety is of paramount

importance. No extension of prescribing rights (which increases the likelihood of an adverse event) is acceptable to the RACGP.

There is no clear evidence that nurse-doctor substitution saves money or reduces the workload of GPs. Efficiency gains are not observable due to a high level of task duplication and patient confusion around role delineation.[4,5] Although nurse prescribers under GP supervision may allow for more task substitution, a qualified GP must still be available to work with or supervise their role. This ongoing supervision increases time burden and liability for GPs, particularly in rural and remote areas, and nullify any benefit of task substitution. Further, the complexity of the clinical governance framework required to support such task substitution suggests it would unlikely be cost-effective for employers.

The rationale for introducing the proposal can be managed through existing mechanisms

The stated rationale of the NMBA's proposal is to increase access to medicines for patients in underserved communities through improving workforce flexibility. It is the RACGP's understanding that RNs already facilitate increased access to medicines in underserved areas. Therefore, the RACGP does not see a need to expand the prescribing role of RNs more broadly.

Convenient does not necessarily equal quality healthcare. While allowing more RNs to prescribe medicines may increase patient access, access to services alone does not benefit patients. Patients need access to *safe, comprehensive* and *high-quality* health services.

Encouraging multiple prescribers will contribute to the growth of a two-tiered healthcare system. As a result, patients who cannot access GP services (for example due to cost or geographic location) will instead see the nurse as their first point of contact. This has the potential to reduce equality of care and increase health disparities for already disadvantaged communities.

The RACGP acknowledges the need to address medical workforce maldistribution issues that particularly affect patients located in rural, remote or Aboriginal and Torres Strait Islander communities. However, expanding the scope of practice for RNs is not a long-term solution. Patients in these communities have the right to the same standard of medical care as patients in metropolitan and regional areas.

The RACGP continues to advocate for and support initiatives which strengthen rural general practice and increase the number of doctors working in rural and remote Australia and other areas of workforce shortage.

2. After reading the proposed registration standard and guidelines, in your view, are there any additional elements that should be considered by organisations in establishing governance arrangements for prescribing in partnership?

Healthcare reforms must support coordinated and continuous care

Evidence shows that continuity of care through long-term ongoing relationships between patients and GPs is associated with lower preventable hospital admissions and lower risk of mortality.[6, 7, 8, 9] These effects are shown to be particularly beneficial for older patients and patients with multi-morbidity and polypharmacy.[10]

Opening up prescribing to RNs could divert patients away from their GP. We acknowledge that the proposed definition of 'partner prescriber' includes GPs. However, the definition also includes non-GP prescribers, which creates the potential for registered nurses to prescribe medicines with no involvement from the patient's GP.

A visit to your GP is not just about prescription. A recent analysis of over 1.5 million GP-patient encounters in Australia confirmed that the majority of GP appointments made specifically to request medication actually resulted in additional healthcare needs being addressed during the same visit. [11] Losing this important opportunity for comprehensive and integrated care could prove detrimental to patients.

When a patient presents for a GP consultation, a range of other healthcare service opportunities are provided including:

- preventive health screening and advice
- health checks (e.g. for patients with diabetes)
- health education
- updating of health records
- building of the therapeutic relationship between patient and doctor.

Our GP members report frequently seeing patients who have attended 'just for a script renewal' and who then go on to express (for example) depressive feelings. This spontaneous disclosure then leads to initiation of potentially life-saving interventions.

A patient's regular GP can provide informed, tailored advice to patients by drawing on:

- often long-term personal relationships
- the patient's medical history held by the practice
- records of the patient's current treatments and medications.

As stated in the foreword of the National Prescribing Service's *Competencies required to prescribe medicines*, it is 'most important' that a person have one main healthcare provider to coordinate healthcare and collaborate with other healthcare providers.[12]

3. Two years' full time equivalent post initial registration experience has been proposed as a requirement for applying for endorsement. Do you think this is sufficient level of experience?

And

4. The NMBA is proposing that the education for registered nurses should be two units of study that addresses the NPS Prescribing Competencies Framework. Do you think this level of additional education would appropriately prepare an RN to prescribe in partnership?

The NMBA's proposal to require two years' post-registration experience, and complete two units of additional study, is insufficient to facilitate quality prescribing.

Prescribing medicines is not always as straightforward as it may initially appear, and is a responsibility that should not be taken lightly. Many patients suffer from multiple chronic conditions with a complex interplay of medications and medical conditions. Managing these requires the expertise that doctors gain from study across a number of disciplines over at least nine years' graduate and postgraduate training, the majority of which focuses on distinguishing diagnoses.

RNs do not have the same breadth of training required to assess a broad range of undifferentiated health problems, and should not be expected to provide the same level of care. Nurse prescribing of medicines may result in unusual (and sometimes serious) conditions not being recognised and managed appropriately due to a lack of adequate training and expertise.

Prescribers need to have a clear understanding of drug-disease, drug-patient and drug-drug relationships, including:

- an adequate knowledge of all likely clinical presentations, from acute self-limiting conditions to chronic and complex disease, and understanding of the natural course of disease
- insight into the consequences arising from multiple pathology in one person
- competence in predicting which medicine best suits individuals with different characteristics
- insight into the Quality Use of Medicines (QUM), e.g. the effect of a medication on a frail elderly person (drug-patient interaction), with impaired renal function (drug-disease interaction), who

takes a wide range of medications for multiple conditions (drug-drug and drug-disease interactions); and responsible prescribing of antibiotics in the context of growing concern about antibiotic resistance

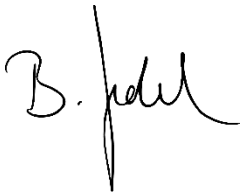
- ability to assess the significance of multi-dimensional drug interactions to avoid harm and gain benefits for the patient.

The RACGP is concerned that introducing additional prescribers will increase volume of prescribing without consideration of quality de-prescribing and appropriate non-drug interventions. De-prescribing (reducing the amount of medications) is an active process for GPs in the context of the patient's medical history and the broader QUM perspective, and is increasingly becoming the focus of quality improvement activities within general practice. If patients present to an RN for a prescription, there is reduced opportunity for meaningful medication review.

While the RACGP understands the proposal is not to allow RNs to prescribe independently, it is important to acknowledge that prescribing, even in partnership, requires significantly more in-depth experience and training in diagnosis, treatment and drug interactions than can be provided in two units of training. Prescribers without the appropriate knowledge and skills would lead to more adverse events and increased use of GP time monitoring the prescriber.

I hope the RACGP's response to the consultation paper is of assistance. If you have any further questions or comments regarding this correspondence, please contact myself or Ms Susan Wall on 03 8699 0574 or via susan.wall@racgp.org.au.

Yours sincerely



Dr Bastian Seidel
President

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