## Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Victorian Department of Health and Human Services (the Department) for the opportunity to respond to the consultation on proposed changes to Victorian nurse practitioner prescribing arrangements.

The RACGP acknowledges the valuable contribution that nurse practitioners make to the Australian healthcare system. The RACGP supports the proposed approach, provided nurse practitioner prescribing takes place only within their defined scope of practice and under the appropriate collaborative care agreements.

## Answers to consultation questions:

- *Do you support the proposed approach to authorise Victorian nurse practitioners to obtain and to use, sell or supply any Schedule 2, 3, 4 or 8 poison (medications) in the lawful practice of their profession?*

It is noted that this change will bring Victorian nurse practitioner regulatory requirements into closer alignment with those of other states and territories. The RACGP supports changes which reduce the administrative burden on health practitioners and regulators, so long as the changes do not negatively impact patient safety.

The RACGP position statement on nurse practitioners in primary healthcare allows that clinical roles, responsibilities and accountabilities within a GP-led general practice team should be assigned according to each health professional's level of education, training, supervision and clinical expertise. As such, prescribing by nurse practitioners within their defined scope of practice, as proposed by the Department, is appropriate.

General practices should remain patients' first point of contact within the healthcare system and retain ultimate oversight of patient care. Prescribing by non-medical practitioners should only occur as part of a medically-led team-based model of care under the direction and supervision of a medical practitioner – for example via collaborative care agreements. This will help ensure compliance with best practice, prevent the occurrence of adverse events and maintain continuity of patient care.

The quality use of medicines requires the close cooperation of all prescribers before the addition of any new medication for a patient. Poly-pharmacy (the concurrent use of five of more prescription medications), over-the counter or complementary medicines, can constitute a particular risk to patient safety. Collaborative care agreements should clearly state the extent to which any drugs may be autonomously prescribed by the nurse practitioner, as well as make clear the importance of involving the usual GP to avoid drug-drug or disease-drug interactions, especially in the elderly or those with comorbidity.

The RACGP has recommended to the MBS Review Taskforce that collaborative care agreements should be more closely monitored and regulated. The RACGP provides guidance on how collaborative care agreements should be developed, and what should be documented, in its Guide for collaborative care agreements in general practice.

- *Do you believe there are any unintended consequences that would result from the proposed approach?*

RACGP member feedback has cautioned that nurse practitioners in primary care must work within GP-led teams to avoid the risk of fragmentation of patient care, and unnecessary duplication of health services. Prescribing is a responsibility that should not be taken lightly. Medication misadventure can cause adverse patient events, avoidable hospitalisations, and indemnity risk.

- *Would any Victorian be disadvantaged by the proposed approach?*

The RACGP does not see that the proposed approach would disadvantage any Victorian, provided the appropriate safeguards are in place, as described above.