ANZCA
FPM

Te Whare Tohu o
Te Hau Whakaora

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Ministry of Health | Manatū Hauora
By email: info@health.govt.nz

Tēnā koe

Consultation on amendments to the specified prescription medicines list for designated registered nurse prescribers in primary health and specialty teams

Te Whare Tohu o Te hau Whakaora | The Australian and New Zealand College of Anaesthetists (ANZCA) welcomes the opportunity to provide feedback on the above consultation, proposing

- the inclusion of 190 medicines and four medicine classes to the designated registered nurse prescribers specified prescription list and
- the removal of restrictions for seven medicines currently listed.

About ANZCA

ANZCA, which includes the Faculty of Pain Medicine (FPM) and Chapter of Perioperative Medicine, is the leading authority on anaesthesia, pain medicine and perioperative medicine. It is the professional organisation responsible for postgraduate training programs of anaesthetists and specialist pain medicine physicians, and for setting the standards of clinical practice throughout Australia and Aotearoa New Zealand. Our collective membership comprises 9649 fellows and trainees in anaesthesia and pain medicine, of which about 1300 work in Aotearoa New Zealand. ANZCA is committed to upholding Te Tiriti o Waitangi in the provision of competent, culturally safe care, and to promoting best practice and ongoing continuous improvement in a high-quality health system.

Consultation

We have consulted with our members, in particular the Chairs and members of ANZCA's New Zealand National Committee (NZNC), FPM NZ, Clinical Directors Network, Māori and Pacific networks, and Directors of Professional Affairs (DPA) in New Zealand and Australia. As a binational college, ANZCA constantly reviews and compares factors that impact anaesthesia, perioperative and pain medicine in both countries, providing support and advocacy for high-quality health care.

We have also clarified some issues with Nursing Council of New Zealand with regard to the context and conditions under which registered nurse prescribers are able to prescribe, being assured that many of the medicines on the list would only be used for continuation prescribing where a diagnosis has been made and in specialist areas following discussion with the specialist or General Practitioner (GP) or Nurse Practitioner (NP) as relevant. Registered nurse prescribers are required to work in a collaborative team within a specified area of practice and within their experience and competence.

Overview

Before commenting on the specific proposals, ANZCA acknowledges that access to medicines in Aotearoa is inequitable, that Māori, rural and vulnerable consumers often do not get the medicines

they need to reach their health potential and consequently experience preventable suffering, ill-health and shorter life expectancy.[1- 2]

The college recognises the significant impact that workforce and other issues ancillary to medicines and prescribing regulation have on access to medicines. We know that there are communities without doctors, where nurses, paramedics, and pharmacists are expected to deal with whatever "comes through the door ". While Telehealth may bridge some gaps, the reality is that non-medical colleagues are often left trying to service already vulnerable communities, where substance misuse and the associated crime may be rife. There is also the added risk of undue pressure and threats that practitioners in sole charge/remote situations face.

Achieving the right balance between safety and access in this context[3] is difficult and depends heavily on the responsible authorities (RAs) regulating practitioners and ensuring appropriate education and training. ANZCA has confidence in the current regulatory regime for health practitioners but is less sanguine that health workforce policy and planning is sufficient to meet the current and future health needs of all New Zealanders.

The consultation documents provide very little context for the proposed amendments, but for ANZCA, health equity including equitable access to medicines, is a priority. The documents do not detail how the rollout of registered nurse prescribers will be evaluated, aside from describing the standard audit and prescribing data analysis that are in place to improve prescribing practice for registered nurse prescribers, as for other prescribing practitioners. The frequency of these audits is unclear and ANZCA would encourage steps to evaluate registered nurses' prescribing practice upon rollout.

One advantage of increasing the range of medications for registered nurse prescribers is to move away from standing orders. In the non-hospital setting, standing orders require a lot of oversight and individual review for each nurse that has administered medication via standing order. It is labour-intensive to complete the audit requirements of standing orders and often difficult to ensure a GP or NP has adequate time for oversight. Verbal orders can be used at times, but there are some medications, for example narcotics, that cannot be given via a verbal order. Making sure that prescribing is within scope and within a specific team setting and ensuring that high-risk and specialist drugs are listed as "continuation of a prescription" are sensible precautions; it may also be relevant to refer to specific professional body guidelines and routes of administration.

While extending the prescribing list will undoubtedly increase access to medications, there may be a risk of confusion with multiple prescribers in some settings, which will require careful management by the medical practitioner in charge. The college is particularly wary of medications where there is a high risk of addiction, abuse or 'nurse/doctor shopping'. It is not clear that the 'palliative care and acute pain practitioners' requesting changes to the controlled drugs include medical specialists with a vocational scope of practice in pain medicine and post-specialisation qualification through the FPM of ANZCA. The college urges extreme caution in expanding access to these controlled drugs and recommends consulting with the FPM before proceeding with the proposed amendments.

There is also some tension between the requirement for registered nurse prescribers to work in a collaborative team within a specified area of practice, when a key rationale for expanding the list of

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[1] Metcalf, S., Beyebe, K. Urlich, J. Jones, R. Proffitt, C. Harrison, J., Andrews, A.Te Wero Tonu- The Challenge Continues: Māori access to medicines 2006/07-2012/13. NZMJ.Wellington. Nov 2018, vol 131,No 1485.

[2] Pharmac. Achieving Medicine Access Equity in Aotearoa New Zealand: twoards a theory of change. New Zealand Goverment. Wellington.

[3] Medical Council of New Zealand.Whārangi Moiōho Fact Sheet. Available from: New News article | Medical Council

medications they can prescribe is that they are effectively isolated. It is essential that the registered nurse prescriber has access - remote or kanohi ki te kanohi - to the advice, guidance and support when they need it to support decision-making. Progressing regional digital capability and interoperability is necessary to underpin safe collaboration. There remains a general concern with the shortage of doctors and medical specialists which increases the load on registered nurse prescribers and the potential for the inefficiencies and risks associated with 'scope creep'.

However, the evidence suggests that nurse prescribing in Aotearoa improves equity and access to medicines, particularly for Māori and those in rural and high deprivation areas and is safe. Only three nurses have been referred to Nursing Council for prescribing breaches, and no complaints have gone on to the Health Practitioners Disciplinary Tribunal (HPDT) or Health and Disability Commissioner (HDC). [4-6] Designated registered nurse prescribing in specialty teams began in 2011, and registered nurse prescribing in primary health and specialty teams was introduced in 2016. Registered nurse prescribers are supported by post graduate education in advanced assessment and diagnostic reasoning; pathophysiology; pharmacology and 150 hours of supervised practice.

Registered nurse prescribing has been recently introduced in Australia and enables access to the full schedules of Australian medicines.[5].There are, however, significant differences with nurse prescribing in Australia and Aotearoa. Australian registered nurse prescribers are required to be under direct supervision and are more equivalent to New Zealand's third level of nurse prescribing in community health[6] rather than second level registered nurse prescribers in primary health and specialty teams. Expanded Australia registered nurse prescribers' capability will require partnership with authorised health practitioners under a clinical governance framework and an active prescribing agreement.

As indicated in the college's submission on the *Medicines Amendment Bill* earlier this year[7], the specified medicines list is large, unwieldy, and difficult to keep up to date. We recommend that the Ministry investigates a more flexible and enabling prescribing approach to medicines, specifically where the list is based on class or subclass of medicine, rather than the existing approach of naming specific medicines, which we consider the best option. Section 105 (1) (qa) *The Medicines Act 1981* specifically authorises regulation of:

> "any class of registered health professional to prescribe specified prescription medicines, or a specified class or description of prescription medicines, in accordance with any conditions, limitations, requirements, or restrictions specified in or imposed under the regulations."

We recommend the individual concerns/queries expressed in the following section below are considered and mitigated, for example with specific education and/or reference to professional body guidelines, before proceeding with the proposed amendments to the specified prescription list for designated registered nurse prescribers in primary health and specialty teams. Patient safety is paramount and best protected where multidisciplinary teams work together to provide coordinated, collaborative and continuous patient care.

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[4] Pearson M, Papps E, Walker RC. Experiences of registered nurse prescribers; a qualitative study. Contemp Nurse. 2020 Aug;56(4):388-399. doi: 10.1080/10376178.2020.1813044. Epub 2020 Sep 16. PMID: 32814514.

[5] AHPRA, Nursing and Midwifery Board of Australia - New standard to enable registered nurse prescribing

[6] Key, J. Hoare, K. Nurse prescribing in New Zealand—the difference in levels of prescribing explained. NZMJ 30 October 2020, Vol 133 No 1524 Accessible from NZMJ 1524.indd

[7] ANZCA. Submission to the New Zealand Health Committee on the Medicines Amendment Bill. May 2025. Availablefrom: 2025-04-Medicines-Amendment-Bill,-ANZCA.pdf

Proposed additions to the medicines list

Anaesthetics

- **Remove the restriction 'opthalmic use only' Atropine** - it is not clear what the broader, non-ophthalmic conditions(s) are that would require registered nurse prescribing.
- **Bupivacaine and Ropivacaine** - ANZCA appreciates the need for a nurse prescriber to use a short-acting local anaesthetic like lidocaine/lignocaine, however the rationale is less clear for longer acting agents with greater toxicity like bupivacaine or ropivacaine, which carry greater risks for the patient. Training in recognition and treatment of Local Anaesthetic Toxicity is essential if being used in significant doses if being used in the community for post-operative pain. It may be appropriate to add *Intralipid* as it is an important part of the treatment of toxicity.

Cardiovascular system

- **Amiodarone**- Continuation rather than nurse-initiated prescribing only. "This is a difficult and challenging drug to use in clinical practice because of its very prolonged half-life and multiple adverse effects"[8].
- **Prazosin** - There is no clear rationale offered for this medicine, which is not a routine first or second line antihypertensive agent. Authorised prescriber only.
- **Bosentan/ Ambrisentan/ Selexipag** - The side effects of these medications for treating pulmonary hypertension are significant. They are used to treat a very specialised condition, and patients will be under the care of a cardiologist. Authorised prescriber only
- **Perhexiline** - This is an end stage anti-Anginal and is beyond the scope of a nurse prescriber. Authorised prescribers only.
- **Metaraminol/ Midorine/ Phenylephrine** - Anaesthetists must always be available to oversee and prescribe or give a standing order for these medicines used in post anaesthesia care units (PACU). It must be also clear who is ultimately responsible for the hypotensive patient in PACU.

Central nervous system

- **Pregabalin** - Addiction and abuse is an issue with this medication, we advise extreme caution and would not support nurse-initiated prescribing.

Endocrine system

- **Desmopressin** - The rationale for registered nurse prescribing is not clear. Large doses can have haematological effects and impact sodium. ANZCA recommends guidelines for dose and route limits.

Nutrition and blood

- **Drugs used in haemophilia** - These are specialist medicines which should only be prescribed by an authorised prescriber.

Skin

- **Agents for dermatitis excluding corticosteroids** -These are very powerful immunosuppressants which are not generally prescribed for dermatitis. Without a clear context, it is questionable that a registered nurse would need to be able to prescribe these agents.

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[8] Campbell TJ. Amiodarone. Aust Prescr 2005;28:150. https://doi.org/10.18773/austprescr.2005.112

Infections

- **Antibiotics** - Education for registered nurse prescribers for these specialised medicines is noted**.** These need oversight of infectious diseases, particularly if there are complex long-term infections.

Controlled drugs

- **Addition of ketamine** - Acute pain and palliative care are appropriate settings. ANZCA strongly cautions against the use of ketamine for chronic pain.
- **Removal of 'transdermal only' for Buprenorphine and removal of sublingual for Buprenorphine with naloxone** - Buprenorphrine can cause challenges in the perioperative management of patients. We are concerned that removing transdermal/ sublingual applications could open the way for its use as weight loss medication, rather than prescribing in an addiction setting. In the expanding field of weight loss medications there seem little appreciation that this may lead to more patients turning up for surgery with an opioid antagonist onboard, making pain relief more complex and difficult to manage.
- **Removal of 'transdermal only' for Fentanyl and removal of 'oral only' for methadone** - ANZCA recommends a requirement for specific training and certification for safe prescribing of these drugs which are common sources of opioid misadventure in the hands of inadequately trained health practitioners. We suggest the prescribing of fentanyl should be restricted to acute pain and palliative care settings only.

Recommendations

ANZCA recommends that you:

- **Clarify** what steps will be taken to evaluate registered nurse prescribing practice upon rollout .
- **Consult** with the FPM on the prescribing controlled drugs used to treat pain with a high risk of addiction and abuse.
- **Provide** extended training and support to registered nurse prescribers including specific education, referral to professional body guidelines and ensuring access to the information and authorised prescribers needed for safe decision-making.
- **Consider** moving to a more flexible and enabling prescribing approach to medicines based on class or subclass of medicine.
- **Agree** that the continued critical shortage of doctors due to lack of retention and poor workforce planning, is a fundamental barrier to equitable access to medicines.

Once again thank you for the opportunity to submit. We trust the above is useful.

Nāku noa, nā

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Australian and New Zealand
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