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Sharon Woollaston
Senior Policy Analyst
Ministry of Health
No 1, The Terrace
Wellington

Tēnā koe Sharon

Draft Standing Order Guidelines

The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the above following a review of the recently updated Medicines (Standing Order) regulation. We have consulted members and staff, in particular our Colleges and Sections and professional nursing, policy and legal advisers. We have also consulted with the wider nursing community, and this feedback is supported by the College of Nurses Aotearoa. We advise that we have fielded a number of enquiries from both nurses and general practices about the new regulations.

In general we welcome changes intended to reduce the administrative burden of countersigning all standing orders (SO), and note that the checklist is a very useful addition to the document. However we are aware that there is still extensive variation in the way standing orders are used, with consequent risks to safety on the one hand and flexibility on the other. We suggest the disparities may be attributable to a general lack of clarity or transparency around how prescribing and diagnoses fits in with SO which allow for wide and inconsistent interpretation. The intention of SO is for use *in particular circumstances* for *registered health professionals* to meet a *specific medication need* for a *specific client group* to ensure timely access to medicines. The guidelines for SO should not allow for a broader interpretation for more general prescribing as, for example, in the GP practice which states that SO apply:

When accredited nurses are caring for patients during office hours, the patient needs medications and a general practitioner is not available to write a prescription. Stored medications are therefore provided to the patient, or a prescription is generated which can later be signed by the issuer of the standing order.

Another set of SO from elsewhere in the country advises nurses to print and sign (pp) a prescription in the absence of a doctor and where there is no 'office' supply of the drug required.

The prescription is stamped with the words *Issued under Standing Orders*. The question of whether these SOs constitute nurse prescribing may fairly be raised in both these circumstances, in which case they are outside the remit of SO and pose a risk to both nurse and patient.

Similarly, NZNO's Gerontology Section has noted the risk carried by registered nurses (RNs) when providing SO medication to patients who have no specific diagnosis for their presenting symptoms, particularly in the frail older adult who often has an atypical presentation. Paradoxically, the same lack of precision in SO can constrain the autonomy of registered health practitioners, and the potential for innovation.

With imminent legislation finally acknowledging Nurse Practitioners (NPs) as authorised prescribers; robust parameters around the extended scope of practise for RNs; and the Diabetes Nurse Specialist prescribing pilot, there is a clear trend towards safe, flexible and integrated healthcare, to ensure New Zealanders' timely access to the medicines they need. The guidelines for SO regulation must also recognise this trend and enable health practitioners to fully utilise their scopes of practise to maximise both the efficiency of the health workforce and protection of public safety, as per the intent of the Health Practitioners Competence Assurance Act (2003). The Responsible Authorities under the Act determine the parameters of safe, competent practice; SO guidelines should be consistent with the new RN expanded scope of practice and endorse the circumstances in which prescribing fits within it.

The process for developing and using SO must be collaborative and specific to the service needs, so those acting under SO - generally nurses - understand and accept what they are signing up for. SO should not be developed by authorised prescribers alone, nor used as a generic cover for situations when they may not be available. Student health services, for example, typically require immediate treatment for large numbers of people with urinary tract infections and sexually transmitted diseases, and it is entirely appropriate that, having identified that specific need, that RNs are able to treat these conditions under SO.

Family Planning New Zealand (FPNZ), for example, has excellent, concise and clear guidelines around SO and good education practises. Nurses safely and competently conduct 75% of around 180 000 consultations, which cover the treatment of uncomplicated STIs and vaginal conditions so that doctors are free to deal with clients with complex conditions such as bleeding problems, PCOS, and infertility, where differential diagnosis may be a feature of the assessment. FPNZ emphasise the importance of training; their model and the process by which it was developed may be a useful one to refer to or follow.

To accommodate both safety and flexibility, the SO guidelines need to be more specific about what is acceptable and under what circumstances. NZNO suggests that careful selection of a number of key scenarios illustrating acceptable boundaries would be useful. Indeed we suggest that realistic scenarios with guiding principles would be more effective than lengthy, detailed instructions trying to cover every circumstance. We have one example of a set of SO which are 188 pages long and cover an extensive range of conditions and treatments. They are well written and follow the guidelines, but it is a moot point as to whether this is the intention of SO, as there are no stated parameters in the guidelines.

The proposed introduction of another prescriber category, that of delegated prescriber, is another factor contributing to the already complex mix of circumstances, settings and professional practises regulating prescribing. It is not clear how, or if, this new and unheralded category of prescribers will be affected by SO, but certainly considerable concern has already been expressed across the sector about the potential for confusion, and it would be useful if this indirect concern was acknowledged. NZNO strongly questions the statement by David Wood, Deputy Director General, Strategy and System Performance Directorate (Regulatory Impact Statement Medicines' Amendment Bill, Ministry of Health, 20 September 2011) that "*The proposal for delegated prescribing was publicly consulted on in 2007. There was strong support for the general proposal*." NZNO's recollection is that discussion on alternative prescribing centred on collaborative prescribing and that there was insufficient surety and detail about it to reach any consensus, cross-disciplinary or otherwise. Certainly NZNO does not support it.

NZNO is anticipating there will be a full Select Committee hearing process for the Medicines Amendment Bill which will enable robust consultation on this new category of prescriber. No less than four reviews of the obsolete Medicines Act have taken place over the last decade and a half, without result, and it is unacceptable, in our view, that when necessary reforms are finally imminent, this new and potentially confusing, unsafe, and unnecessary category is being included.

Definitions

Clauses 3, 4, 6, and section 2 in the checklist. NZNO is aware that with the Medicines Amendment Bill, NPs will cease to be designated prescribers and that a consequential amendment to the SO regulation will be required for NPs to be issuers of SO as authorised prescribers. We note that currently the Medicines Amendment Bill does not list a consequential amendment to the SO regulations, nor is one listed for the Misuse of Drugs Regulations 2005 allowing NPs to prescribe controlled medicines. NZNO would like to be assured of the intention that a supplementary order paper with the necessary consequential amendments will accompany the Medicines Amendment Bill when it goes to the Select Committee, to ensure that NPs will not only be named as authorised prescribers but will be able to practise as such. The protracted process of removing the barriers preventing this highly educated and expert group of nurses from utilising the full extent of their scope of practise has had far-reaching and negative consequences for nursing and for health. There can be no margin for error or further delay. NZNO would like to be kept fully informed as to this point.

Once the legislation with the consequential amendments to SO regulations has gone ahead, NZNO suggests you consider amending the guidelines using the term "authorised prescriber" to refer to all issues of SO, rather than listing practitioners from specific disciplines. We note that a review of the scope of practice will be needed for Nurse Practitioners when they become authorised prescribers as proposed in the Medicines Amendment Bill.

People working under standing orders

Clause 8: NZNO recommends explicit clarification that unregulated health care assistants (HCAs) or equivalent (practice assistants, for example) should not be permitted to supply or administer medication under SO as there is a requirement that an assessment of the patient must be made prior to the supply or administration of the medicine. Such assessment and the suite of competencies surrounding registered clinicians' professional responsibility for medication

administration are outside the domain of HCAs' or practice assistants' job descriptions. The distinction is particularly important in the residential aged care sector where lack of mandatory safe staffing protocols and recent contractual changes dropping the requirement for a manager to be a clinician, increase the pressure and risk of HCAs undertaking work for which they are neither trained nor qualified, but are held responsible for. Emergency Department admissions for medication errors, the Health and Disability Commissioner and the Nursing Council of New Zealand's acknowledgement of the disproportionate numbers of referrals from aged care settings, and the considerable experience of NZNO staff and members, testify to the risk to public safety that ambiguous regulation allows.

Process

Clause 9: We suggest that the guidelines specify that the development of the standing orders must be a *collaborative* process beginning with staff - usually nurses - identifying the service needs. A recommendation that staff be involved is patently inadequate as previous examples have shown, where SO processes have been written by authorised prescribers generally to cover situations where they are unavailable.

"any person affected by the standing order" We suggest that this is too broad; we assume, for instance, that patients would not be issued with a SO.

Record Keeping

Clauses 15 and 16: We again recommend clarifying that an HCA or equivalent cannot supply or administer medicine under a SO. The issuer determines the level of competency the person must have, but the Guidelines do not make it clear that HCAs are excluded from this process.

Countersigning Standing Orders

Clause 18: We reiterate our support for increased flexibility in the guidelines on countersigning standing orders. We also note that many workplaces now have electronic records only, with traditional paper medication charts for both the issuer and the administering personnel to sign becoming obsolete in some areas of practice. We suggest that the guidelines could refer to safe protocols for electronic management of SO records.

In conclusion, NZNO strongly recommends further interdisciplinary discussion and consultation in the development of the SO guideline and refer you to Hilary Graham-Smith, NZNO Associate Professional Services Manager, who can be contacted on hilaryg@nzno.org.nz or 07 858 7202., NZNO's Professional Services Manager, Susanne Trim is leading consultation on the Medicines Amendment Bill; she can be contacted on 027 283 6627 susannet@nzno.org.nz.

We trust this feedback is useful and thank you again for the opportunity to contribute.

Nāku noa, nā

Marilyn Head

Policy Analyst
Phone: 04 494 6372
Email: marilynh@nzno.org.nz

ABOUT NZNO

NZNO is the leading professional and industrial organisation for nurses in Aotearoa New Zealand, representing over 45 000 nurses, midwives, students, kaimahi hauora and health workers on a range of employment-related and professional issues. Te Runanga o Aotearoa comprises our Māori membership and is the arm through which our Te Tiriti o Waitangi partnership is articulated.

NZNO provides leadership, research and support for professional excellence in nursing, negotiates collective employment agreements on behalf of its members and collaborates with government and other agencies throughout the health sector. Nurses are the largest group of health professionals comprising half the health workforce.

The NZNO vision is "Freed to care, Proud to nurse". Our members enhance the health and wellbeing of all people of Aotearoa New Zealand and are united in their professional and industrial aspirations to achieve a safe, sustainable and accessible system of public health care for all New Zealanders.