New Zealand Nurses' Organisation (Inc.)

Submission to the Ministry of Health

on the

Review of the Policy Relating to the Operation of the Medicines (Standing Orders) Regulations 2002:

a discussion document

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Executive Summary

1. The New Zealand Nurses' Organisation (NZNO) welcomes the review of the policy relating to the Standing Orders Regulations. NZNO strongly believes that the review should extend beyond the countersigning requirements once a standing order has been initiated. NZNO has identified other areas within the policy and Regulations that are problematic. These matters were notified to the Ministry in October 2003 as an outcome of the NZNO national survey on the utility of the regulations introduced in December 2002. NZNO urges the Ministry address these issues also during this current review.

Recommendations

2. The NZNO recommends that you:
   - **agree that** the review should extend beyond the countersigning requirements;
   - **agree that** the countersigning requirements are relaxed;
   - **agree that** the annual review requirement is relaxed;
   - **agree that** the sign-up requirements to the standing order are relaxed; and
   - **note that** the availability of the written standing order requirement is clarified.

The New Zealand Nurses' Oganisation (Inc.)

3. NZNO is the lead professional body for nurses and the leading nursing union in Aotearoa New Zealand. Our members include nurses, midwives, students, health care workers and other health professionals. The NZNO is a Te Tiriti o Waitangi based organization which represents 39,000 members, the majority of whom are nurses working with standing orders.

4. The NZNO vision is "Freed to care, proud to nurse". Our members enhance the health and well being of all people of Aotearoa New Zealand through ethically based partnerships and meeting the health need of New Zealanders. Our members are united in the achievement of their professional and industrial aspirations.

NZNO Policy and Position on the Review

5. NZNO, concerned about the utility of the standing orders policy and regulations introduced in 2002, undertook a national survey of nurses and nursing leaders in all sectors of the health service during the latter half of 2003. The survey results (Appendix A) identified a number of concerns about the operationalisation of the standing orders regulations, including the countersigning of standing orders once they had been initiated. The difficulties in complying with the standing orders regulations and policy had inhibited and constrained nursing practice and efficient, timely patient care in a number of areas. NZNO sent the report and recommendations to the National Nurses' Organisations and the Ministry of Health in October 2003.

6. NZNO supports this current review of the Standing Orders policy however NZNO is concerned that the review seeks to address only one identified problem when there are other areas which need to be addressed also. NZNO believes it timely to address all the identified difficulties in the policy.

Policy Review Specifics

7. The NZNO survey identified the following policy areas as requiring review:
    - Signup requirements to the standing order;
    - Clarification around the availability of the standing order to staff;
    - Countersignature of the administered or supplied treatment within a specified timeframe;
    - The inability of supply/administration of restricted and pharmacy-only medicines under standing orders. This concern has subsequently been addressed; and
    - The annual review of competency when additional competencies are determined by the issuer.

Countersigning requirement

8. Compliance with countersigning an administered or supplied treatment by the issuer within a specified timeframe was found to be the most difficult area to achieve. In some cases, inability to comply had inhibited or even stopped certain service delivery with a resulting delay in treatment initiation. Compliance with this requirement is particularly problematic for outreach types of nursing services.

9. NZNO supports relaxing the requirement to countersign every supply and/or administration of a treatment given under a standing order. NZNO supports each standing order, as it is drawn up, identifying whether an issuing clinician is required to countersign the treatment once it has been given. Where a countersignature is not required, the checks and balances to monitor the safety of that standing order should include:
    - Critical incident reporting systems; and
    - A random audit of treatments administered under a standing order by the issuer or a delegated medical signatory to the standing order and a nurse leader.

    The frequency of the random audit should be stipulated in the written standing order document. This may depend on the particular drug or treatment initiated, for example, if the standing order is for a simple analgesic then the random audit may be only six monthly but if it was for insulin initiated by a diabetic nurse specialist in newly diagnosed diabetics a monthly audit would be appropriate. NZNO believes that those drawing up the standing order should be able to use their discretionary clinical judgment to determine the frequency of audit requirements.

Annual Review of Standing Order by the Issuer

10. The annual review requirement is of questionable value to patient safety and has considerable resource implications. NZNO proposes that this requirement is relaxed.

11. A new standing order could be reviewed after the first year and then have up to a three yearly review date depending on the treatment to be initiated. The review date should be set by the issuer and noted on the written standing order. There should be professional discretion by the issuer in determining the appropriate review timeframe depending on the clinical context and the treatment type. For example, a treatment initiated within a complex clinical intensive care setting may require an annual review, whereas a bowel treatment standing order for constipation in an aged care setting may require only three yearly review.

Sign-up to the standing orders requirements

12. In large facilities where many health practitioners are involved, where there is a frequent rotation of staff, and where there is locum coverage, the sign-up requirement is an operational difficulty. NZNO is aware that a number of service providers have key health professional staff (clinical directors and nurse managers) sign up to the standing order on behalf of other staff. It is questionable as to whether this complies with the policy.

13. NZNO supports the policy being relaxed to enable signing up on behalf of staff. Nurses are aware that if they are uncomfortable in initiating a standing order they should not do so but seek direct medical consultation. The standing order stipulates any specific competencies required to initiate the standing order.

Availability of a copy of the standing order to every person affected

14. It is unclear in the policy whether a copy is required to be held by every person affected or whether availability to access a copy in the clinical practice environment would suffice. NZNO recommends that the policy clarifies this point and that access to a copy held in the clinical practice environment suffices.

Conclusion

NZNO welcomes a review of the policy relating to the operation of standing orders. Currently there are a number of difficulties in achieving compliance. They extend beyond the countersignature requirement for all treatments once one has been initiated, although that countersignature is the most urgent and significant matter to be addressed in this review. NZNO recommends that the other policy areas identified in this submission are addressed as well as the relaxing of the countersigning requirement.

Susanne Trim
New Zealand Nurses' Organisation

Appendix A

NEW ZEALAND NURSES ORGANISATION

Report of NZNO Survey on

Standing Orders Regulations:

the utility of the regulations introduced in December 2002

October 2003

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Introduction:

Regulations setting out minimum requirements for the use of standing orders for the administration and supply of medicines under the Medicines Act 1981 and the Misuse of Drugs Act 1975 came into force 19 December 2002. They provide legal clarity around standing orders and cover the use, content and application of the standing orders.

A number of matters were raised with NZNO on the introduction of the Regulations about their utility, in particular,

- the inability for midwives to issue standing orders,
- the sign-up requirements to the written standing order,
- the requirement for annual review for standing orders such as hospital wide simple analgesics,
- the counter-sign off requirements by the medical practitioner or dentist once a standing order has been utilised,
- specific impediments which may be experienced by outreach, district and rural nurses in particular.

In an effort to try to clarify specific problems or issues and to quantify them, NZNO has conducted a survey of Directors of Nursing, nurses and midwives. The survey was widely distributed through Nurse Executives of New Zealand, New Zealand Nurses Organisation specialty Colleges and Sections, Regional Councils and the Nursing and Midwifery Advisory Committee, other professional nursing groups, the Rural Nurses Network, the Plunket Association, New Zealand Family Planning Association and the Aged Care Forum (Canterbury). The NZ College of Midwives were asked for their opinion on the exclusion of midwives from issuing standing orders. Additional information was requested from the NZ Ambulance Service and the Defence Forces to determine and compare their experiences with the Standing Orders Regulations.

Copies for information were sent to the Chief Adviser – Nursing, Ministry of Health, the Nursing Council of New Zealand and the Nurse Educators of the Tertiary Sector.

The survey tool was developed with input from the South Island Nurse Executives of New Zealand. The survey was distributed in July 2003 with a response deadline of 31 August 2003. The survey and invitation to participate is appended (Appendix A).

Results:

In total 53 submissions were received by the due date. The submissions came from a widespread geographical area and a variety of health service providers, nurses and midwives.

The results have been grouped and reported in sectors for ease of analysis. Responses to questions indicating that there was no problem have not been specified.

1. The Public Sector

Public Sector Directors of Nursing

Eight responses were received from DHB Directors of Nursing or those delegated to respond on their behalf.

All respondents indicated that standing orders were used or were being developed for use. Two indicated that they had previously used standing orders and had stopped them when the Regulations were introduced while they were reviewed for compliance with the new Regulations.

Respondents indicated the size of their organisations and the number of health professionals involved resulted in difficulties in signing up to and reviewing standing orders annually. One organisation responded:

> "*All staff do not sign a copy of standing orders. These are signed by Nurse Manager on behalf of clinical nursing staff. They then inform their staff.*"

Another said:

> "*Sign off is difficult with staff rotations, turnover and locums. With guidelines looking at specific individual sign off we will develop most sign off into unit based protocols approved by the Clinical Governance Group.*"

This respondent also noted that there were

> "*difficulties in establishing practice processes to ensure compliance.*"

They noted the point that many over the counter (OTC) drugs could be purchased and administered freely by the public and that these would be useful to put under standing orders but the process (Regulations) was very bureaucratic and that bureaucracy hindered the development of new standing orders and ability of health professionals to use these drugs appropriately.

The number of health professionals involved in these public sector organisations also meant that the requirement for medical practitioners to countersign the implemented standing order medication was difficult. One noted that:

> "*Large organisation and the sign-off regulations are unworkable therefore in our new policy, it has been agreed by Clinical Board that a nominated signatory be permitted to countersign on behalf of the issuer.*"

Another DHB stated that this requirement has

> "*Terminated all nurse-led specialist activities in community settings as it is completely prohibitive and [we are] unable to comply.*"

One respondent noted that

> "*I have two or three areas where they would be beneficial … but I'm not sure if it is worth going through the process.*"

Diabetes Nurse Educator

One response from a DHB diabetes nurse educator who did not use standing orders.

Small/Rural Public Sector Hospitals

Two respondents indicated that standing orders were used to cover emergency situations as 24-hour medical practitioner cover is not available. No issues/problems were noted.

Registered Nurses in Major Public Hospitals

Nineteen responses were received from charge nurses, nurse specialists and staff nurses from major hospitals in five DHBs.

One CCU nurse indicated that the standing orders in the DHB had been rescinded since the introduction of the Regulations however there are major clinical problems with this because nurses are now unable to administer medications in an arrest before medical help arrives. This would potentially have a negative impact on patient outcomes.

Another day surgery unit manager drew attention to the "*tedious*" process in establishing standing orders providing an example of the seven months taken to develop a standing order for pre-medication for the first two cases on the gynaecological day surgery list. She stated "*it becomes easier not to have them.*"

Other respondents noted that they did not "sign up" to a standing order nor receive a copy, but operated under them. They also noted the difficulties in having medical practitioners countersigning an implemented standing order and this was not often done in practice. One respondent noted:

> "*The most significant difficulty is the requirement for the issuer to sign off on each administration, e.g. we have a standing order for the administration of paracetamol to children who meet particular criteria. If the clinical director (CD) is the issuer this means the CD is required to countersign the administration of paracetamol. This is logistically impossible.*"

Another respondent questioned the validity of standing orders in acute care settings where there is 24-hour access to medical cover.

A number of respondents indicated that there had been standing orders in use but they had now stopped with the introduction of the Regulations.

2. Aged Care Sector

Four responses were received relating to the aged care sector. They included:

- public sector aged care assessment, treatment, rehabilitation, day care and outreach services
- NGO hospital, palliative and district nursing (generalist and specialist) services
- private rest home and hospital facility
- infection control nurse consultant to aged care sector

The public sector provider did not utilise standing orders however they were currently under consideration. The main problem foreseen to implementation was the sign off requirements and ensuring all staff were conversant with the Regulation requirements.

The NGO provider had utilised standing orders until the Regulations were enacted but subsequently had found they were unable to comply with the Regulations and had ceased to use them. The standing orders had been used for pharmacy-only and restricted medications which cannot be supplied or administered under standing orders until law changes enable these two classes of medications to be included.

The private hospital provider utilised standing orders without problem in complying to the Regulations.

The infection control consultant commented on the indiscriminate use of OTC antifungal powders and creams used inappropriately in many long-term care facilities and recommended that the use of these treatments should come under the Standing Orders Regulations.

3. Primary Health Care Sector

<u>Rural Nursing and Nurse-Led Primary Clinics</u>

Four submissions were received from:

- education provider health clinic (nurse-led)
- manager rural nurse-led clinics (public sector)
- individual rural nurse
- manager rural trust services

Standing orders were used in all cases.

All respondents stated that a copy of the document with those signing up to it is held in the facility. Only two responded that there had been compliance with the requirement that all staff involved have made available a copy of the standing order. The other two respondents were unaware of this requirement under the Regulations until receiving the survey.

In response to the question (12) of the survey re approval and sign off of the standing order by an appropriate manager of the health provider, a mixed picture is provided. There may be no "manager" per se but a "team" of appropriate people which may be the same health professionals developing the standing order and signing up to it as issuers and users.

One independent nurse-led clinic found problems with the requirement for the medical practitioner to counter-sign the implemented standing order medication charge within a specified timeframe. The respondent stated:

> "*We work in a community with no GP. We perform 13 self-referral clinics weekly. We have standing orders formulated by capitated GPs only to be used for their patients. A checklist and consultation note is sent by fax after each consult. The GPs don't sign this [as] they have signed the original standing order.*"

General Practice Settings and Community Care Nursing Teams

Seven responses were received from nurses working for IPAs, within General Practice settings or divisions of the NZ College of Practice Nurses[NZNO].

One response was received from an IPA Community Care Nursing Team offering home-based nursing services.

The seven responses from practice nurses indicate a mixed picture with some practices using standing orders whilst others do not. One IPA has developed generic standing orders which may or may not be utilised within individual practices. That decision is made by the practice.

One group of practice nurses indicated that when standing orders were utilised in their various practices, they were implemented but not countersigned afterwards by the doctor. This group saw compliance with that requirement a difficulty. Generally only one copy of the standing order was held and the various practioners may or may not formally sign it.

The Community Care Nursing Team utilises standing orders without any identified problems to date.

Individual copies held by all parties and confirmation of agreement to the standing order(s) have not been complied to at this point.

School Health Clinic

One response came from a nurse working in a nurse-led sexual health school clinic. Standing orders were used with no difficulties noted in complying with the regulations.

4. Private Surgical Hospitals

Three responses were received from private surgical hospitals. All three noted that standing orders were used. None had a resident medical practitioner on site.

All respondents stated that medical practitioners either did not countersign the medication once a standing order had been implemented or there was difficulty in meeting this requirement and it required persistence by the RN to be achieved. One respondent stated that:

> "*This seems unreasonable in our work setting. All medications under standing orders are signed as given by the nurse administering it, but we have not expected a doctor's countersignature as well as the actual [signed] standing order that outlines all the details*."

Two respondents noted difficulty developing and complying with the requirement of writing and signing off the standing orders due to the number of attending surgeons and anaesthetists, and this factor contributes to difficulties in achieving an annual review of the orders.

5. Other

Family Planning Association

Standing orders are in draft format awaiting finalisation. Doctor cover and availability to countersign administration will be problematical. There is also a stated concern that if the competencies will be reassessed by the issuer via the performance appraisal system of nurses, then doctors may wish to have greater input on nursing assessment beyond the standing order competencies. This respondent queried the appropriateness of this foreseen consequence.

Asthma and Respiratory Foundation of New Zealand

The Foundation became aware of NZNO's survey and notified NZNO of their interest in pursuing the possibility of improving asthma management through the use of standing orders. They have been in correspondence with the Thoracic Society, NZMA, and held discussions with the RNZCGPs re this. Compliance with the Regulations in the countersigning of medication use or change is seen as a problem and barrier to this initiative.

St Johns Ambulance New Zealand

The request for information regarding utilisation of standing orders by ambulance officers has been forwarded to the St Johns sector body Ambulance NZ. No response was received at time of writing this paper.

Defence Forces

Extensive standing orders have been developed. The only difficulty reported has been in developing and complying with the requirement for signing off the standing order. The respondent stated that:

> "*The time frame cannot often be met due to the operational settings where the Standing Orders are used. Example: When a Navy Vessel deploys with a medic and no doctor there may be a delay in sign-off until the vessel returns to port. The same may apply in the field in NZ or on operations overseas in the absence of a medical officer.*"

An individual respondent from a practice working for the defence forces related that the current exclusion from standing orders of the pharmacy only and restricted medicines classifications *"puts us up the creek"*. Many of the drugs they have administered under standing orders fall within these classes of medicines. They have continued to operate under standing orders this year in ignorance of the exceptions.

6. Midwives

Nine respondents stated that midwives worked in their facility. None indicated that they saw a need for midwives to issue standing orders.

The New Zealand College of Midwives (NZCOM) was asked to provide an opinion on the standing orders Regulations and whether they should be broadened to include midwives as able to issue standing orders. In their response they stated:

> "*The NZCOM has debated the impact of midwives not having the ability to issue standing orders and the conclusion has been that this is not a concern for [them] professionally.*"

They go on to say:

> "*We do not therefore support any attempt to include midwives as part of the standing orders legislation review …*"

Analysis:

Responses were received from primary, secondary and tertiary sectors and encompassed both public and private providers. The geographical spread included most regions of New Zealand and respondents from rural, urban and metropolitan services. Respondents included both the managers/advisers of nursing services and nurses using standing orders in their practice. The results provide a snapshot of the use of Standing Orders and the issues that have resulted with the introduction of the Standing Orders Regulations on 19 December 2002.

The majority of respondents (88%) using standing orders in their facilities stated they were fully conversant with the Standing Orders Regulations. However a number of them provided information later in the survey which indicated that this response was not fully accurate and that there are some of the finer points of the Regulations that are not well known. This was evidenced by

- Some stating that they had not realised that the Regulations specified the provision of copies of the Standing Order being made available to every person permitted to supply or administer it.
- A number of those responding to questions 12 and 13 were either unsure of whether the Standing Order had been signed off by an appropriate manager of the health provider. These respondents were mainly those using the standing orders in larger facilities. In answering the question, *Who is deemed an appropriate Manager for signing off the standing order?* a variety of responses were received. This is to be expected but a number stated that the clinician issuing the standing order was the appropriate manager of the health provider (general practice responses were not included).
- A number of queries following up from the survey were received directly by NZNO from some of the respondents regarding the status of restricted and pharmacy-only classes of medications which are not covered by the Regulations at present. They were unaware that these categories were excluded until further law changes are made.

Ten respondents who indicated that standing orders were not used in their facilities also indicated that it was intended that they be introduced, while four respondents said that there was no intent to introduce standing orders. Of the fifty-three respondents then, only four stated that standing orders were not in use and there was no intent to use them in the future. This would demonstrate that the use of Standing Orders is widespread throughout many health services within New Zealand.

Of concern, was the response from one District Health Board that the introduction of the Regulations had terminated all nurse-led specialist activities in community settings because of an inability to comply with the Regulations. This was echoed by some registered nurse respondents from the public sector and an NGO provider in the aged care and home-based nursing sector which had stopped using standing orders with the introduction of the Regulations.

The key areas identified where there were difficulties in complying with the Regulations were

- The length of time to develop, get agreement to and sign off in writing the standing order when multiple health professionals were involved,
- In facilities where large numbers of staff and rotations of staff occur, the sign up to the standing order, compliance with the requirement that all staff involved have a copy made available is difficult to achieve,
- Annual review is deemed to be a problem particularly in larger organisations or those where there are many health professionals involved and changing staff patterns.

- Countersigning of the implemented standing order medication chart by the issuer of the standing order. It is this requirement that has resulted in the cessation of standing orders for nurse-led specialist activities of at least one DHB and the aged care NGO provider, and poses significant difficulties in other settings,
- The current exclusion of restricted and pharmacy-only medications is very restrictive in the range of medications which can be administered under standing orders.

The difficulty in complying with the Regulations is hindering the use of standing orders in a number of areas and has actually constrained appropriate nursing practice in the outreach areas of one DHB respondent.

There are clearly logistical issues in large hospitals where staff turnover rates, rotational training systems, and availability of the issuer of a standing order make compliance with the Regulations a problem. A number of "creative" policies and processes have been put in place to try to address these logistical difficulties but it is questionable as to whether they meet the legislated requirements.

The requirement to countersign the medication chart once a standing order has been acted upon is a significant problem in a variety of settings. These settings include:

- Training hospitals with a rotational turnover of doctors, issuer availability for signature and duty doctors covering a variety of speciality areas beyond their base ward after hours,
- Outreach and speciality nurses who are adjusting medications according to symptoms and response to dosage/medication. These nurses often carry multiple cases, are located in their "home base" infrequently and rarely when medical practitioners are there and have variable access to the main case files. To have multiple medical practitioners sign-off multiple files in these circumstances is not possible,
- Hospitals where there are visiting doctors and no 24 hour resident medical practitioner (eg private surgical hospitals) have difficulty in obtaining the counter signature and to obtain this often takes considerable valuable nursing time in contact and repeated follow-up, and
- Nurse-led clinics and rural nurses – the physical distance means that this requirement is rarely met in practice.

The responses indicate that the Regulation requirements regarding the content of the Standing Order have not posed a problem although the development of the written standing order has become a more bureaucratic and time-consuming process.

Many organisations are only beginning to introduce processes to monitor and review the correct operation of the standing order and any adverse events and no problems have yet been identified in this requirement.

Document control processes appear to be well in hand with organisations having established processes.

There is no support to extend the Regulations so that midwives can issue standing orders.

Discussion:

A snapshot of current use and difficulties in compliance with the newly introduced Standing Orders Regulations has been provided in the responses to this survey.

It appears that the finer detail of the Regulations is not well known by those using Standing Orders although the respondents in more senior positions were fully conversant with the requirements. Of concern is the number of responses stating that respondents were fully conversant with the Regulations but later responses in the survey indicating that this was not the case. This lack of detailed knowledge of the Regulations has resulted in the implementation of standing orders in a number of areas which do not meet fully the legislated Regulations and thus nurses, doctors and organisations are exposed to potential risk.

It was of interest that a number of organisations, recognising that some Regulations would be difficult to comply with, had introduced organisational processes to overcome those perceived difficulties. These included systems to

- "streamline" sign-up requirements to the standing order,
- copies of the standing order being centrally held rather than being held individually by each signatory, and
- alternatives being introduced to counter-signature of the implemented standing order by the issuer.

It is questionable as to whether these adjusted processes would stand up to legal scrutiny should a question of practice and compliance with Regulations arise. Once again this exposes nurses, doctors and organisations to potential risk.

Other organisations recognising the difficulties in compliance had stopped the use of standing orders altogether in some services. It has to be asked whether this has been in the best interests of patients or not. In one example given, that of the cardiac arrest, it could be postulated that the absence of standing orders may have a negative outcome for patients. Also, the DHB which reports that nurse led activities such as the effective use of Diabetes Nurse Specialists has been hindered because of an inability to comply with the Regulations, particularly the counter-signature of an implemented standing order, is a worry. The constraint of nursing activities such as this reduces the flexibility of appropriate service delivery and timely intervention in patient care and it increases waiting times for medication change, health care costs and implementation of best practice. This is surely counter to the purpose of the Standing Orders Regulations which was to provide legal clarity around the practice but not to constrain it.

The lengthy and detailed processes in development, sign up to the standing order, making available copies to each staff member using them are considered to be bureaucratic and

certainly the impression from reading the manner in which the responses were written, was one of annoyance with high compliance costs when more streamlined processes can achieve the same outcome. In fact, a number of organisations have developed different systems, by holding central registers in the work place and a master copy for the organisation's records.

Responses are silent on signing up new staff to an existing standing order, for example, newly appointed staff, locums and incoming registrars and house-surgeons. It has to be questioned as to whether this occurs or not. Certainly informal discussions with rural nurses by this author have clearly indicated that in rural practices there are some difficulties in using standing orders when locum doctors are in the practice or when DHB base hospital staff are the key contact people.

Also a number of hospitals have standing orders which cover most patients and staff in their facility, for example, the use of simple analgesics or bowel medications. It is difficult to envisage how the sign-up to such a standing order of several hundred staff would be managed and compliance with the Regulations could be achieved.

The **annual** review of standing orders by the issuer is of questionable value to patient safety and has considerable resource implications. It is reasonable to set a maximum timeframe for which a standing order can be in place without review, but is it more appropriate to have flexibility within this stipulation depending on the medication and situation for its use. Thus for some standing orders an annual review is reasonable whilst for others such as the simple analgesic example given above, a three yearly review period may be more appropriate and reasonable. That decision could be made by the issuer based on the clinical context and the medication type and the review timeframe noted on the written standing order.

The current exclusion of restricted and pharmacy-only classifications of medicines is seen to be restricting the potential use and benefits standing orders unnecessarily. Dr Stewart Jessamine, MedSafe Ministry of Health, is working on the law changes required before these two classes of medicines can be included, and he has been contacted (24 September 2003) for a progress report. No further information had been received at the time of writing this report.

Countersigning a standing order medication record by the issuer after its implementation appears to be the most difficult compliance area. Difficulties arise in a variety of contexts, including nurses working in more independent roles (outreach, nurse-led clinic, rural practice) and for those in hospitals with many health practitioners (training hospitals and private surgical hospitals).

Prior to the introduction of the Regulations last year, it was common practice for a nurse to implement a standing order, record that the medication had been given or adjusted in the medication chart and noting the reason for implementing the standing order and the relevant changes in the clinical record progress notes. The nurse signed the medication chart and the clinical record, but this was not usually countersigned by the doctor. The

medical clinician read of the change in the clinical record when the patient was next reviewed or if the implementation of the standing order did not achieve the desired outcome, the nurse would follow-up by direct contact with the medical practitioner.

The implementation of this Regulation requirement has been difficult to achieve in practice with the outcome being either halting the use of standing orders, increased nursing time in following up repeatedly with medical practitioners to have the medication chart countersigned or else ignoring the requirement altogether. Often it is not the issuer of the standing order who countersigns it either but another medical practitioner on a team. It is reasonable to ask whether the countersignature by the issuer on the medication chart serves a particular purpose or not, and whether a return to the previous practice would fulfil that purpose. For example, is the signature meant to be a check to see that the standing order was implemented appropriately? If so, then would not the clinical record note also serve that purpose. Also the Regulations state that the issuer must put in place a process for monitoring and reviewing the correct operation of the order and the Director General may audit any standing order from time-to-time.

No issues with complying with the minimum requirements for the content of the standing orders were identified. There is obviously high compliance with these requirements and they are achievable.

The annual review of competency of those permitted to supply or administer a medicine by the issuer may be problematical, particularly if there are large numbers involved and more than one standing order is issued by one practitioner. It would be more pragmatic for the competency review to be undertaken by the issuer or person(s), they deem to be appropriate.

No organisational or practice problems were identified in midwifery practice and the inability for midwives to issue standing orders and thus there is no need to extend the regulations in this area.

At present New Zealand has only one independent nurse prescriber and as more are endorsed as prescribers, the need for independent nurse prescribers to be identified as a group who may issue a standing order will need consideration.

Conclusion:

This survey has identified that standing orders have wide use within New Zealand health services but that there are some difficulties with full implementation of the Standing Orders Regulations which were implemented on 19 December 2002. These difficulties have created barriers to full use of standing orders in some areas and compliance difficulties have exposed nurses, doctors and organisations to potential risk.

The main areas of concern needing consideration and review are

- sign-up requirements to the standing order
- making the standing order available to all staff involved. The Regulations are not clear as to whether this is by providing a copy or whether a copy suffices.
- annual review of each standing order by the issuer
- countersignature (within a specified timeframe) of the administered/supplied treatment
- the current inability of supply/administration of restricted and pharmacy-only medicine classes under standing orders
- the annual review of competency, where additional competencies are determined by the issuer

In addition, the introduction of the Regulations have constrained appropriate and safe nursing service delivery in some contexts and have the potential to hinder timely nursing intervention. The further development of more autonomous nursing roles and responsiveness could be constrained by difficulties in compliance with the current Regulations.

Recommendations:

1. It is recommended that the National Nurses Organisations (NNOs) of New Zealand receive this report, consider the recommendations and determine an approach to progress modification of the current Standing Orders Regulations.

2. It is recommended that NNOs seek a review and modification of the Medicines (Standing Order) Regulations 2002, clauses:

5 What standing order must contain

(j) - specify period within which the issuer must countersign the charted treatment; and

(k) - specify if a policy relating to the standing order exists, attach a copy of that policy, which must have been signed by the issuer, the management of every health provider in which the standing order operates, and every person supplying or administering under the standing order, as applicable

6 Annual review of competency

7 Annual review of standing order

8 Obligations of issuer

(c) he or she countersigns the chartered treatment or record, as the case may be, within the required period stated in the standing order/

3. It is recommended that NNOs consider whether there is a "gap" between the use of standing orders and independent nurse prescribing, and if the "gap" is

significant, consider options for future development. Options may include collaborative prescribing arrangements with named physicians for clinical nurse specialists.