# AMA Victoria's response to the Nurse Practitioner Prescribing Arrangements Consultation Paper – December 2019

16 December 2019

The Australian Medical Association (Victoria)

## Introduction

The Australian Medical Association (Victoria) welcomes the opportunity to provide feedback to the consultation on extending authorisation for Victorian nurse practitioners.

AMA Victoria is strongly opposed to the proposal to expand the medicines list to enable nurse practitioners to obtain, have in their possession and to use, sell or supply a Schedule 8 poison in the lawful practice of their profession. AMA Victoria also has reservations about the prescription of certain Schedule 4 medications with narrow therapeutic indices.

Nurses whose registration is endorsed under the *Health Practitioner Regulation National Law* (s. 94), may be authorised to possess, supply and administer scheduled medicines in the lawful practice of their profession.

Since 1 July 2010, Nurse Practitioners (NPs) working in Victoria have had to apply to the Nursing and Midwifery Board of Australia (NMBA) for a notation on their registration related to the category in which they practice. As NPs expand their scope of practice over time and need to be able to prescribe medicines that are in another category, they are required to apply to the NMBA to have more than one notation on their registration, aligned with their individual scope of practice and education preparation.

The current proposal by the Department of Health and Human Services (DHHS) is to remove this requirement, as it creates an additional burden on NPs. The amendments proposed in the Consultation Paper provide an opportunity to address the lists of poisons associated with the existing NP categories, as described in the Victoria Government Gazette, 9 July 2009, 29 April 2010, 1 July 2010 and 22 August 2019.

AMA Victoria is strongly opposed to this proposal to expand the medicines list to enable NPs to obtain, have in their possession and to use, sell or supply a Schedule 8 poison and prescribe certain Schedule 4 medications with narrow therapeutic indices.

It is not clear that there is a firm evidence base to support that the current mechanisms governing Victorian NP prescribing is not working, or needs to be changed significantly. No evidence has been presented, for instance, as to the number of avoidable fatalities that this expansion to the medicines list will prevent.

## Recognition of the important role of nurse practitioners working in GP-led teams

AMA Victoria recognises the valuable role nurse practitioners play as part of a General Practitioner-led health team.

In 2007, DHHS funded a collaborative practice model of care (CPM) pilot. The primary objective of the pilot was to improve the sustainability of care in rural Victoria and to test a new model of collaborative practice between general practitioners and registered nurses who provide emergency care in rural hospitals and health services.

The outcomes of the pilot indicated that nurses operating within a CPM, with an extended scope of practice, improved the capacity of rural health services to deliver consistently high quality urgent care services.[1]

AMA Victoria asserts that General Practitioners must remain a patients' first point of contact within the health care system. Expanding the scope of practice for nurses and other allied health practitioners could increase the fragmentation of care and is not the

[1] Ibid.

solution to addressing resource challenges in Victoria's health system. Furthermore, international and Australian evidence strongly supports that GP-led multidisciplinary teams achieve optimal health outcomes for patients.

## Schedule 4 medications with narrow therapeutic indices

AMA Victoria also has reservations about the prescription of certain Schedule 4 medications with narrow therapeutic indices. Drugs with narrow therapeutic index (NTI-drugs) are drugs with small differences between therapeutic and toxic doses, implying that small changes in dosage or interactions with other drugs could cause serious adverse effects.

Drug-related problems arising from NTI-drugs have been found to be associated with increased morbidity, mortality and health costs.[2,3,4] Therefore, preventing drug-related problems would benefit both patients and society. Despite the lack of definite lists of NTI-drugs, the understanding of which drugs should belong to the NTI group are by and large similar among drug experts. These drugs include: aminoglycosides, cyclosporin, carbamazepine, digoxin, digitoxin, flecainide, lithium, phenytoin, phenobarbital, rifampicin, theophylline, and warfarin. We would recommend that if NP's are to prescribe such drugs, then additional training or supervision will be required to prevent adverse events.

## Patient safety and risk management

The AMA's position is that only medical practitioners are trained to make a complete diagnosis, monitor the ongoing use of medicines and to understand the risks and benefits inherent in administration and supply of restricted and controlled drugs.[5]

The current proposal to expand the medicines list for NPs relates to the administration and supply of poisons, up to and including Schedule 8 controlled drugs.

Schedule 8 medicines are controlled drugs and there is a reason why these medicines are classified as Schedule 8 - specifically these medicines are drugs with both therapeutic properties but also serious side effects and harms.

Schedule 8 controlled drugs are subject to a range of controls under the Act due to additional risks of drug dependence. Further, medical practitioners in Victoria must apply for a *permit* to administer, supply or prescribe drugs of addiction. Doctors are also required to retain detailed clinical records to ensure that drug dependent patients are easily identified.

For some individuals and in some circumstances, potential risks can include severe morbidity and even death.

Supply of Schedule 8 controlled drugs in the absence of a verbal or written instruction from a GP may also contravene an existing permit, and/or opiate contract in place.

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[2] 1. Ernst FR, Grizzle AJ. Drug-related morbidity and mortality: updating the cost-of-illness model. *Journal of the American Pharmacists Association* (2001); 41: 192–199.

[3] Winterstein AG, Sauer BC, Hepler CD, Poole C. Preventable drug-related hospital admissions. *Annals of Pharmacotherapy* (2002); 36: 1238–1248.

[4] Patel P, Zed PJ. Drug-related visits to the emergency department: how big is the problem? *Pharmacotherapy* (2002); 22: 915–923.

[5] The AMA, "AMA Position Statement: Medicines", 2014.

Take for example a Schedule 8 poison like fentanyl. Fentanyl citrate is a synthetic narcotic 100 times more powerful than morphine and 50 times stronger than heroin.[6] As a result, fentanyl carries a significant risk of serious side-effects that require the patient to be monitored when fentanyl is used.[7]

Fentanyl is characterised by a rapid onset of sedation and analgesia, a relatively short duration of action (approximately 30 to 40 minutes), and rapid reversal with opiate antagonists.

A recent Australian study revealed 136 fentanyl deaths between 2000 and 2011, with a staggering 62% having injected fentanyl at the time of death.[8] This poison requires careful dosing and titration, close patient monitoring, and the availability of naloxone hydrochloride and resuscitation equipment.

The other concern AMA Victoria would like to express relating to NP prescribing is the real risk that a patient will find a NP who is prepared to make adjustments to prescription medication in line with the patient's wishes. This may lead patients who seek drugs of dependence to gravitate towards NPs more willing to comply with the patient's desires. AMA Victoria believes that SafeScript cannot be truly effective if patients are able to obtain drugs of addiction from NPs, and especially without such prescriptions being captured by the real-time prescription monitoring framework.

AMA Victoria submits that a GP must always be consulted and issue verbal or written instructions before a NP can supply Schedule 8 drugs, and Schedule 4 medications with narrow therapeutic indices. This is the cornerstone of patient safety and central to good practice and risk management.

## Administration and supply of Schedule 8 controlled drugs

Doctors place a high value on the professional role of NPs and are committed to working with NPs to improve the medication management and clinical outcomes of patients.

However, AMA Victoria strongly asserts that NPs lack in-depth knowledge of the patient's medical history, pharmaceutical interactions and allergies to date. Medical practitioners have superior knowledge of adverse events, doses, optimal routes, drug-drug and drug-food interactions, pharmacokinetics and pharmacodynamics.

As the practitioner with prescribing rights, doctors bear the duty of care and responsibility for decisions they make regarding medicines, including informing the patient and gaining consent.

Concerning urgent prescription arrangements, the 2009 AMA Victoria survey[9] reported that GPs prefer to review the patient's clinical condition before issuing an 'urgent' prescription. At the very least, GPs will review the patient's file before authorising a pharmacist or nurse practitioner to dispense a medication by telephone. Even in urgent care settings, AMA Victoria maintains that patient medication safety and efficacy depends on review by a registered medical practitioner.

To facilitate good communication and foster collaborative care, AMA Victoria endorses the *10 Minimum Standards of Communication between Health Services and General*

[6] Narconon, "Fentanyl drug information", 2017.
[7] Chudnofsky, CR., et al, "The safety of fentanyl use in the emergency department", 1989.
[8] Roxburgh, A., et al, "Trends in fentanyl prescriptions and fentanyl-related mortality in Australia", 2013.
[9] AMA Victoria, "AMA Survey on Pharmacists' Request for Scripts", 2009.

*Practitioners and other Treating Doctors*, developed by the AMA Victoria Section of General Practice (refer ***Appendix 1***).

AMA Victoria submits that a medical practitioner must always be consulted and issue verbal or written instructions before a NP can supply or administer a Schedule 8 controlled drug.

## Medico-legal and ethical issues

This proposal raises serious medico-legal questions around who bears the legal liability for the dispensing of Schedule 8 controlled drugs where a NP administers such a drug independent of GP oversight.

AMA Victoria submits that doctors should not shoulder the responsibility for a decision in which they have not been involved. AMA Victoria supports adhering to the existing hierarchical tenets of patient management. As such, AMA Victoria strongly advocates that NPs should never be able to supply a Schedule 8 controlled drug, without further verbal or written instruction issued by a GP.

In the interests of patient safety and quality of care, supply of Schedule 8 controlled drugs should only occur with the verbal or written agreement of the patient's medical practitioner.

## Concerns around nurse safety and occupational violence

Nurses known to be carrying narcotics are at risk of experiencing assault and violence, including fatal violence, perpetrated by persons attempting to obtain a drug of addiction. Deputising services now travel with security to minimise this risk. Risks of occupational violence have only increased in recent years.

The safety of nurses in rural and regional settings is of particular concern. The tragic attack on South Australian nurse Gayle Woodford was perpetrated by a man known to have abused alcohol, cannabis and engaged in petrol sniffing.[10] Her attacker was reportedly high on ice at the time he attacked Ms Woodford. The attacker in this circumstance was not specifically seeking opioids however, AMA Victoria recognises that drug abuse is more common in rural and regional areas of Australia compared with urban centres. In particular, the use of pharmaceuticals not for medical purposes is higher in remote/very remote areas than in major cities at 5.2 percent, compared with 3.1 percent in major cities.[11] As a result, nurses in rural and regional areas face specific risks to health and safety.

Schedule 8 poisons are largely used in emergency settings by trained, supervised and supported paramedics, or otherwise in controlled healthcare settings by a medical practitioner. There is no indication that NPs with endorsement to supply Schedule 8 medicines would improve patient outcomes. More than likely, NPs known to be carrying Schedule 8 poisons face a heightened risk of occupational violence and threat of harm to their personal safety.

**There is insufficient evidence to support the need to expand the medicines list to enable NPs to obtain, have in their possession and use, sell or supply Schedule 8 medicines.**

**AMA Victoria submits that NPs should never be able to administer or supply a Schedule 8 controlled drug without further verbal or written instructions issued by a GP.**

[10] ABC News, "Gayle Woodford's killer Dudley Davey to spend 32 years behind bars", 2017.

[11] National Rural Health Alliance, "Illicit drug use in rural Australia", 2017.

**APPENDIX 1**

*10 Minimum Standards of Communication between Health Services and General Practitioners and other Treating Doctors*

# AMA Victoria's 10 Minimum Standards for Communication between Health Services and General Practitioners and other Treating Doctors

***February 2017***

**Introduction**

This Standards document has been informed by the AMA Position paper General practice/hospitals transfer of care arrangements – 2013[i]. It has been developed by AMA Victoria's Section of General Practice and the AMA Victoria Policy Unit.

**Purpose**

AMA Victoria Section of General Practice has developed this **"10 Minimum Standards"** document to facilitate discussion with the Department of Health and Human Services Victoria, public and private hospitals, General Practitioners (GPs) and other treating doctors in order to drive key processes to enhance clinical safety, improve health outcomes, reduce avoidable hospital presentations, reduce risk, improve patient experience and improve resource efficiencies across our Victorian health system.

**Context**

For most patients who receive an episode of care from a health service, the episode comprises one part of their treatment, management, care or recovery journey. This is particularly the situation for people whose conditions are episodic, ongoing or 'chronic'.

For most patients in Australia, their General Practitioner is the main provider of ongoing health care. A person's General Practitioner plays a critical role in co-ordinating responses to their patient's health care needs, including making relevant referrals to specialist non-admitted care, admitted care, allied health care services and social support. They also continue the patient's health care after any medical event or change that has resulted in a care episode in hospital. General Practitioners also work in tandem with medical specialists who medically manage and treat the patient in non-admitted care settings, such as health service specialist outpatient clinics and other health practitioners that work in outpatient health care services. This role of the patient's general practice to function as a health care home is important at many levels, well evidenced to improve health outcomes and supported by the Australian Medical Association.

In order that a patient's care is safe, effective and efficient, adequate and timely communication of information between all medical and health professionals, who provide care to the patient, is required. This needs to occur between all treating health practitioners at all stages of the patient journey; starting from the community setting, through to acute or sub-acute care, and on subsequent 'return' to the community and clinical handover back to a person's General Practitioner.

When appropriate and effective transfer of care practices between General Practitioners other treating doctors and health services and are undertaken, re-admissions are reduced and adverse events minimised. There is also an improvement in satisfaction and experience for patients, carers, families, doctors and other health practitioners.

**Stakeholders**

The most important stakeholder are patients, their carers and families as improved communication leads to better health outcomes and improved patient experience.

Practical examples include reducing the frequent need for patients to repeat fundamental information or undergo repeat investigations and preventing medicine mismanagement due to poor communication between providers.

The other major stakeholders of these requirements include General Practitioners/ other treating doctors, health services and health professionals.

For both health services, and General Practitioners, adherence to these Standards will help achieve and demonstrate performance against their respective Quality Standards by demonstrating the policies and systems required for good communication.

Government is also an important stakeholder as the outcomes of improved communication between General Practice and Health Services will improve efficiency and sustainability, increase patient and carer satisfaction and strengthen service performance.

**Who do these Standards apply to?**

These standards are principally concerned with health services, General Practitioner and other medical professionals. Health Services may be public or private. These Standards scope emergency care, admitted care and non-admitted care episodes[12]

[12] See Glossary at end of this document.

## THE 10 STANDARDS IN SUMMARY

### Standard 1: Referral information from a practitioner to a health service

*A referral to a health service from a General Practitioner includes information for an assessment of the need for care in their setting, triage, and the requirements for the patient's access to the health service.*

### Standard 2: General Practitioner Details

*The name and contact details of a patient's General Practitioner and/or practice is verified and updated on the patient record at each episode of care by the health service.*

### Standard 3: Supported Access to a General Practitioner

*When patients do not have a regular General Practitioner, the health service has a process to support patients to locate a General Practitioner and/or practice and to attend for follow-up care.*

### Standard 4: Timely Communication

*The health service has a system for timely communication directly to a patient's General Practitioner and other treating doctor(s) on the conclusion of every episode of care, after sentinel events and periodically during ongoing care.*

### Standard 5: Handover back to a General Practitioner

*The health service provides General Practitioners with clear and appropriate information to support safe and meaningful clinical handover of patient care.*

### Standard 6: Information Transmission

*The health service has secure and reliable electronic systems to send and receive information to and from the Health Service and General Practitioners and other treating doctor(s).*

### Standard 7: Outpatient services intake and appointment systems

*Specialist Outpatient Services have transparent intake and appointment systems that provide appropriate information and notifications to patients, General Practitioners and other treating doctor(s).*

### Standard 8: Outpatient Services Communication

*There is a system for ongoing and timely clinical communication about patient care between a health care service's Specialist Outpatient Services, other ambulatory and day services and the patient's General Practitioners and other treating doctor(s).*

### Standard 9: Discharge Planning Processes

*The health service has discharge care planning processes for patients with complex needs that involves their General Practitioner and other treating doctor(s).*

### Standard 10: Managing Quality

*These standards are incorporated into the Policies and Quality Systems of General Practices and Health Services.*

## THE 10 STANDARDS IN DETAIL

### Standard 1: Referral information from a practitioner to a health service

*A referral to a health service includes information for an assessment of the need for care in their setting, triage, and the requirements for the patient's access to the health service.*

Elements of this information include, where appropriate to the needs and circumstance of the patient:

- demographic and contact information.
- reason for referral to the health service.
- findings, investigations; medical summary, medicines and allergies.
- an Advance Health Care Plan (when appropriate).
- the person's need for interpreter and cultural support.
- any disability support needs, including advocates and/or alternative decision makers.

Supporting standards and corroborating guidelines for this Standard are:

- The RACGP Standards for general practices (4th edition) Criterion 1.5.2 Clinical handover[ii].
- The RACGP Standards for general practices (4th edition) Criterion 1.6.2 Referral documents[2].

### Standard 2: General Practitioner Details

*The name and contact details of a patient's General Practitioner and/or practice is verified and updated on the patient record at each episode of care by the health service.*

The preferred criteria is the name of the General Practitioner, while the minimum criteria is the name of the practice.

### Standard 3: Supported Access to a General Practitioner

*When patients do not have a regular General Practitioner, the health service has a process to support patients to locate a General Practitioner and/or practice and to attend for follow-up care.*

Minimum criteria for the process includes:

- Relevant staff have access to up to date contact details for General Practitioners for their catchment area.
- Assistance is available for the patient to choose a General Practice and to make a follow up appointment.

### Standard 4: Timely Communication

*The health service has a system for timely communication directly to a patient's General Practitioner and other treating doctor(s) on the conclusion of every episode of care, after sentinel events and periodically during ongoing care.*

Criteria for timely formal communication:

| Circumstances | Timing |
|---|---|
| • Unplanned inpatient admission<br>• Discharge from an inpatient admission<br>• After attendance at an emergency department or short-stay setting<br>• On patient death or other sentinel events | Within 24 hours |
| • Initial Specialist outpatient consultation<br>• Changes in health status or medication at a specialist outpatient service<br>• Discharge from Specialist outpatient clinic | Within 7 days |

## Standard 5: Handover back to a General Practitioner

*The health service provides General Practitioners with clear and appropriate information to support safe and meaningful clinical handover of patient care.*

Supporting standards and corroborating guidelines for this Standard are:
- National Safety and Quality Health Service Standards Standard 6 – Clinical[iii].
- AMA Position Statement - General Practice/Hospitals Transfer of Care Arrangements – 2013[1].

## Standard 6: Information Transmission

*The health service has secure and reliable electronic systems to send and receive information to and from the health service and General Practitioners and other treating doctor(s).*

These should interface with patient information management systems commonly used by General Practitioners and other treating doctors in private or community clinic settings.

## Standard 7: Outpatient services intake and appointment systems

*Specialist Outpatient Services have transparent intake and appointment systems that provide appropriate information and notifications to patients, General Practitioners and other treating doctor(s).*

Minimum criteria include:
- a single point for referral to all specialist outpatient services.
- a publically available system that informs patients and referring doctors of the expected wait for various outpatient specialist services.
- a tracking system to enable patients and referring doctors to determine the prioritisation and status of a given specialist outpatient referral.
- clear, timely and responsive administrative and clinical processes, triggered by notification from a General Practitioner/referring doctor to review the scheduling of a patient's appointment according to clinical circumstances.
- referral from doctor acknowledged within 3 working days of being received.
- a patient's non-attendance of an appointment is notified to referring doctor within 3 working days.
- re-scheduling or cancellation of an appointment initiated by the patient or the health service is notified to a referring doctor within 7 working days.

## Standard 8: Outpatient Services Communication

*There is a system for ongoing and timely clinical communication about patient care between a health care service's Specialist Outpatient Services, other ambulatory and day services and the patient's General Practitioners and other treating doctor(s).*

Minimum criteria include systems:
- for the receipt of updating advice from the General Practitioner or referring doctor about the patient's progress, changes in management, clinical condition or care requirements.
- to enable scheduled secondary consultation with or without the patient directly present at the health care service or general practice.
- to enable telehealth outpatient consultations from the General Practitioner's Clinic when the patient resides in a rural or aged care residential setting.

## Standard 9: Discharge Planning Processes

*The health service has discharge care planning processes for patients with complex needs that involves their General Practitioner and other treating doctor(s).*

Minimum systems for discharge planning processes for patients with complex needs include:

- the ability to undertake telephone, video conference or face-to-face case conferencing prior to discharge that includes the General Practitioner and/or referring doctor.
- outpatients appointment date (if required) scheduled prior to discharge.
- the ability for expedited re-assessment in the Emergency Department if the patient's medical condition deteriorates and warrants the patient's re-presentation within 72 hours following inpatient discharge.
- a documented plan of care and support to be provided to the General Practitioner in addition to discharge summary if Post-Acute Care services are put in place.

## Standard 10: Managing Quality

*These standards are incorporated into the Policies and Quality Systems of General Practices and Health Services.*

Minimum requirements include incorporation of requirements for:

- documentation of policies, procedures, systems and processes that support the attainment of these Standards.
- appropriate Quality Indicators for these requirements are developed, which enable performance monitoring and the measurement of performance improvement initiatives.

## Glossary

***Emergency Care:***
Care provided in an emergency department or emergency treatment/care area

***Admitted Care:***
This includes hospital wards, hospital in the home, acute psychiatry, short stay units, day procedure units, day oncology, bed-based rehabilitation, bed-based Transition Care and other subacute care such as Geriatric Evaluation and Management and bed-based palliative care.

***Non-admitted Care:***
This includes Specialist Outpatient Services, rehabilitation services, community-based Transition Care Packages, community based Specialist Palliative Care and other recovery programs such as cardiac rehabilitation and respiratory rehabilitation programs.

## References

[i] Australian Medical Association. 2013. AMA Position Statement. General Practice/Hospitals Transfer of Care Arrangements – 2013

[ii] Royal Australian College of General Practitioners. 2010. Standards for general practices. 4th edition. Published October 2010 Updated May 2013, updated March 2015, updated July 2015

[iii] Australian Commission on Safety and Quality in Health Care. 2012 National Safety and Quality Health Service Standards Standard 6 – Clinical Handover Safety and Quality Improvement Guide. https://safetyandquality.gov.au/wp-content/uploads/2012/10/Standard6_Oct_2012_WEB.pdf

[4] Specialist clinics in Victorian public hospitals: Access policy. August 2013 https://www2.health.vic.gov.au/getfile//?sc_itemid=%7BE6447CD4-2AD8-48B3-8760-08A028FC788E%7D

[5] Victorian public hospital specialist clinics. Discharge Guidelines. August 2010 https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Discharge%20guidelines

[6] Victorian Auditor – General's Report. Managing Acute Patient Flows. December 2008 http://www.audit.vic.gov.au/publications/2008-09/20081112-Managing-Acute-Patient-Flows.pdf

[7] Victorian Auditor – General's Report. Clinical ICT Systems in the Victorian Public Health Sector. October 2013 http://www.parliament.vic.gov.au/file_uploads/20131030-Clinical-ICT-Systems_ftGBLy2B.pdf