Government of **Western Australia**
Department of **Health**

Consultation report: Prescribing by pharmacists and registered nurses

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Contents

Executive summary

Traditionally, prescribing of medicines has been limited to medical practitioners and dentists. Over the last 35 years, there has been gradual introduction of prescribing by other types of health practitioners. Prescribing by health practitioners other than medical practitioners and dentists is termed ‘non-medical prescribing’.

The Department of Health conducted an eight-week public consultation (5 December 2025 – 2 February 2026) on proposed amendments to the Medicines and Poisons Regulations 2016 to authorise non-medical prescribing by designated registered nurse prescribers (DRNP) and pharmacists.

The consultation sought feedback on regulatory mechanisms, governance controls, and safety considerations relating to prescribing of Schedule 4 (S4, prescription only) and Schedule 8 (S8, controlled drugs) medicines. For DRNP, the consultation also sought feedback on the supply of scheduled medicines available ‘over the counter’ in pharmacies: Schedule 2 (S2, pharmacy medicines) and Schedule 3 (S3, pharmacist only medicines).

A total of 51 responses were received, representing medical, nursing, pharmacy, hospital organisations, consumer groups, indemnity insurers, and individual health practitioners.

Support for a Prescribing Instrument regulatory model

For both professions, stakeholders preferred a regulatory approach that authorises prescribing only when carried out in accordance with a Prescribing Instrument, approved by the Chief Executive Officer (CEO) of the Department of Health. Compared with other regulatory options, this approach was viewed as:

- More flexible and adaptable than embedding detail in regulation.
- Capable of defining essential safety requirements without creating unnecessary barriers.
- Transparent, as instruments would be publicly available.

This model was the Department’s preferred option for both DRNP and pharmacists.

Prescribing by Designated Registered Nurse Prescribers (DRNP)

From 30 September 2025, DRNP are nationally endorsed by the Nursing and Midwifery Board of Australia (NMBA) as qualified to prescribe, in collaboration with an autonomous prescriber, such as a medical practitioner or nurse practitioner. Their practice must occur in accordance with an approved prescribing agreement and organisational governance framework.

Although there was overall support for DRNP being authorised to prescribe, concerns raised included:

- Adequacy of training relative to diagnostic complexity.
- Fragmentation of care and reduced ability for patient follow-up.
- Risks of overprescribing, diversion, and adverse events, especially for S8 medicines.
- Need for access to ScriptCheckWA.

Support for S8 prescribing by DNRP was mixed. Respondents preferred tight restrictions, particularly until DRNP have access to ScriptCheckWA. Suggested safeguards included:

- Limiting S8 prescribing to settings where patients do not have custody of their medicines, such as hospital inpatients and residential care settings.

- Requiring explicit S8 provisions within prescribing agreements.

It was recommended that further targeted consultation be undertaken on any amendments to the Monitored Medicines Prescribing Code to risk-manage S8 prescribing by DRNP.

There were mixed views in relation to DRNP directly supplying their patients with S4 and S8 medicines. Some respondents acknowledged the access benefits in remote and urgent care settings while others cited concerns about loss of safety checks and conflicts of interest. It is recommended that DRNP be authorised to supply the same medicines they may prescribe, which is consistent with existing prescriber classes.

Supply of S2 and S3 medicines was supported by a majority of respondents, recognising DRNP qualifications and alignment with existing prescriber authorities.

Prescribing by Pharmacists

Unlike other prescriber groups, pharmacists do not yet hold a national prescribing endorsement. However, in September 2025, the Pharmacy Board of Australia announced its intention to develop an endorsement for scheduled medicines for pharmacists.

The WA Government has committed to two projects which will require prescribing by pharmacists:

- Enhanced Access Community Pharmacy Pilot (EACPP)
- Collaborative Pharmacist Medication Prescribing (CPMP) (initially hospital based).

While the majority of respondents supported the authorisation of pharmacists to prescribe, concerns raised included:

- Diagnostic limitations and inability to order tests.
- Fragmentation of care and follow-up challenges.
- Conflicts of interest when pharmacists prescribe and dispense in community settings.
- Risks associated with S8 prescribing.

Opposition to pharmacist prescribing was most common from medical respondents, particularly in relation to prescribing in the community pharmacy setting.

Overall, half the respondents supported S8 prescribing by pharmacists, with the role of safeguards being emphasised. Pharmacists already have ScriptCheckWA access, a key information source to support safe prescribing of monitored medicines. Support was higher for pharmacists prescribing S8 medicines in collaborative prescribing models in hospitals compared to S8 prescribing by community pharmacists.

In the context of collaborative prescribing by pharmacists, which is planned to initially occur in public hospitals, stakeholders strongly supported the following requirements in the proposed mandatory Prescribing Instrument:

- Demonstrated competency and assessment processes.
- Governance oversight through the employing/contracting hospital's Drug & Therapeutics Committee or equivalent, including mechanisms for approving prescribing agreements.
- Clear prescribing limits, record-keeping requirements and review and internal audit requirements.
- Separation of prescribing and dispensing.

Prescribing Instrument requirements supported for the EACPP aligned with the requirements already under development for this project including:

- Approved training and CPD.
- Premises and consulting-room standards.
- Secure records and documented treatment plans.
- Clear referral/escalation pathways.
- Compliance with clinical guidelines and protocols.

Most respondents strongly supported allowing the CEO of Health to direct the withdrawal of a prescribing agreement between health practitioners, where risks to patient or public safety are identified and it is recommended the Regulations be amended to allow this. There was also support for using existing powers under the Act for managing non-compliance by prescribers.

The report makes 15 recommendations.

Next steps include Ministerial approval of recommendations, followed by drafting of regulatory amendments. Targeted consultation on the content of the proposed Prescribing Instrument will also be undertaken.

Introduction

Traditionally, prescribing of medicines has been limited to medical practitioners and dentists. Over the last 35 years, there has been gradual introduction of prescribing by other types of health practitioners, in Australia and in many other countries, including countries with similar regulatory frameworks to Australia such as the United States of America (USA), United Kingdom (UK), Canada and New Zealand (NZ). Prescribing by health practitioners other than medical practitioners and dentists is termed 'non-medical prescribing' and encompasses a range of prescribing models.

There are multiple drivers for the development of non-medical prescribing including benefiting patient care by effective use of health professionals' skills, improving access to timely care, increasing patient choice, reducing presentations to emergency departments, reducing hospital admissions and length of stay for admitted patients, enhancing teamwork, and better use of limited health resources. The professions themselves indicate being able to prescribe can result in increased professional recognition and respect, as well as enhanced career development.

In Western Australia (WA), the Sustainable Health Review[1] provides strategic direction for an effective and efficient WA health system. Recommendation 25 of the Review is to 'implement contemporary workforce roles and scope of practice where there is a proven record of supporting better health outcomes and sustainability'.

A 2016 Cochrane Review[2] assessed clinical, patient-reported and resource use outcomes of non-medical prescribing for managing acute and chronic health conditions in primary and secondary care settings compared with prescribing by medical practitioners (usual care). There were 26 studies involving prescribing by nurses and 20 studies where prescribing was by pharmacists. Prescribing tasks included medication initiation, dosage changes and cessation of medication and prescribing could be with, or without, guidance from established protocols and guidelines. The Review concluded that pharmacists and nurses were able to deliver comparable prescribing outcomes to medical practitioners, particularly in relation to clinical outcomes.

The Health Professionals Prescribing Pathway (HPPP)[3], developed by Health Workforce Australia, which was an initiative of the Council of Australian Governments (COAG)[4], describes three categories of prescribing:

- limited prescribing in accordance with defined protocols or from a defined formulary
- prescribing in a formal collaborative arrangement with a medical practitioner or other autonomous prescriber (sometimes termed 'supplementary prescribing' or 'supervised prescribing') and
- autonomous or independent prescribing.

The HPPP can be described as a hierarchical model, although the HPPP acknowledges that a health professional may work within more than one model of prescribing within their clinical practice. For example, the prescribing model currently used for endorsed podiatrists and

[1] The final report, recommendations and implementation progress are available at: https://www.health.wa.gov.au/Improving-WA-Health/Sustainable-health-review
[2] Available at: https://doi.org/10.1002/14651858.CD011227.pub2
[3] Health Workforce Australia, Health Professionals Prescribing Pathway (HPPP) Project – Final Report, 2013.
[4] The primary intergovernmental forum in Australia from 1992 to 2020.

endorsed optometrists is independent prescribing but from a defined formulary (list of medicines). The HPPP is intended to apply to all prescribers: medical practitioners, dentists and non-medical prescribers.

In 2012, the National Prescribing Service (NPS) published the first edition of the Prescribing Competencies Framework, which was also intended to apply to all prescribers and described the competencies required for health professionals to prescribe medicines judiciously, appropriately, safely and effectively in the Australian healthcare system. The National Prescribing Competencies Framework was recently reviewed by the Australian Health Practitioner Regulation Agency (AHPRA) and the third edition was published in September 2025[5].

Although the *Medicines and Poisons Act 2014* defines the word 'prescribe' as the issuing of a prescription, which includes documenting administration orders on a medication chart, this is only one step in the act of prescribing. The HPPP and the National Prescribing Competencies Framework define prescribing as being an iterative or dynamic 'process involving the steps of information gathering, clinical decision-making, communication, and evaluation that results in the initiation, continuation or cessation of a medicine'.

Consultation purpose

The public consultation sought feedback on the most appropriate regulatory mechanism, through amendment of the Medicines and Poisons Regulations 2016, to support non-medical prescribing by pharmacists and registered nurses. In addition, the consultation asked respondents views about constraints to manage risks to patients and the broader public, that may be associated with these classes of registered health practitioner issuing prescriptions.

Other aspects of issuing prescriptions, such as information that must be included on a prescription and prescription formats, including prescriptions issued electronically, are already included in the Regulations and are applicable to all authorised prescribers.

The funding of dispensed medicines, such as via the Pharmaceutical Benefits Scheme (PBS), was not within the scope of the consultation.

Registered nurses

The Nursing and Midwifery Board of Australia (NMBA) has undertaken public consultation on an endorsement for registered nurses to prescribe in a formal prescribing agreement with an autonomous prescriber, such as a medical practitioner or nurse practitioner. The NMBA's Decision Regulation Impact Statement: Registration Standard: Endorsement for scheduled medicines – designated registered nurse prescriber was published on 19 December 2024 and is available online at: https://oia.pmc.gov.au/published-impact-analyses-and-reports/expanded-role-registered-nurses-improve-access-healthcare.

[5] https://www.ahpra.gov.au/About-Ahpra/Our-engagement-activities/National-Prescribing-Competencies-Framework.aspx

At their December 2024 meeting, health ministers from across Australia approved the new registration standard to allow designation of registered nurse prescribers[6]. The NMBA registration standard and accompanying guidelines came into effect on 30 September 2025[7].

Endorsement as a designated registered nurse prescriber (DRNP) means the NMBA considers these nurses to be *qualified* to administer, obtain, possess, prescribe, supply and/or use medicines in Schedules 2, 3, 4 and 8, in partnership with an authorised health practitioner, under a prescribing agreement.

As for all non-medical health practitioners holding an endorsement for scheduled medicines, before these health practitioner classes can issue prescriptions in WA, they must hold *authority* to prescribe under the Medicines and Poisons legislation.

Pharmacists

Over the last few years, various pharmacist prescribing trials and programs have emerged across Australia and, in WA, there are two programs under development, which can only proceed if pharmacists are authorised to prescribe.

In August 2024, the WA government committed to an enhanced role for community pharmacists.[8] It is intended this pilot program will allow community pharmacists to prescribe medicines to patients for a specific range of health conditions. Further detail about the Enhanced Access Community Pharmacy Pilot (EACPP) is available on the WA Health website at: https://www.health.wa.gov.au/Articles/A_E/Enhanced-Access-Community-Pharmacy-Pilot.

In WA Health public hospitals, pharmacists have been writing up orders on medication charts for some years, but the current regulations require a prescriber to sign off on each of these orders before doses can be administered to patients. There is support from the executives of the various health service providers[9], via the WA Health Executive Committee, for pharmacists, with demonstrated competency, to be able to sign off on medication chart orders, particularly in relation to orders for ongoing medications at admission and standardised regimes at pre-admission clinics, such as may be used in certain types of elective surgery. In this prescribing model, pharmacists would be prescribing in a prescribing agreement with the medical team responsible for the patient.

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[6] Health Ministers' Meeting Communique 6 December 2024. Available at: https://www.health.gov.au/resources/publications/health-ministers-meeting-hmm-communique-6-december-2024?language=en

[7] https://www.nursingmidwiferyboard.gov.au/Registration-Standards/Endorsement-for-scheduled-medicines-designated-RN-prescriber.aspx

[8] https://www.wa.gov.au/government/media-statements/Cook%20Labor%20Government/New-expanded-role-for-community-pharmacies-introduced-in-WA-20240809

[9] Health service providers: Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, WA Country Health Service.

Current regulatory framework for prescribing

In WA, the regulatory framework for authorising health practitioners to issue prescriptions for certain types of medicines is through the *Medicines and Poisons Act 2014* (the Act) and the subsidiary Medicines and Poisons Regulations 2016 (the Regulations). Section 25 of the Act provides for the making of regulations that give a defined class of health professional authority to administer, possess, prescribe, supply and/or use a medicine.

The Act and Regulations are only applicable to 'scheduled' medicines. These are medicines included in the 'schedules' of the national Poisons Standard[10] and are defined as follows:

Table 1: Medicines schedules

Schedule	Label heading	Definition	Examples
2	Pharmacy medicine	Substances, the safe use of which may require advice from a pharmacist and which should be available from a pharmacy or, where a pharmacy service is not available, from a licensed person.	Antihistamines Small packs of anti-inflammatory analgesics such as diclofenac and naproxen Paracetamol products for children
3	Pharmacist only medicine	Substances, the safe use of which requires professional advice but which should be available to the public from a pharmacist without a prescription.	Emergency contraceptive pill Chloramphenicol eye drops Salbutamol inhalers
4	Prescription only medicine	Substances, the use or supply of which should be by or on the order of persons permitted under the Act to prescribe and should be available from a pharmacist on prescription.	Antibiotics Antihypertensives Antidepressants Cholesterol lowering medicines
8	Controlled drug	Substances which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.	Oxycodone Tapentadol Dexamfetamine

[10] The Poisons Standard is available via the Commonwealth Therapeutic Goods Administration website at: https://www.tga.gov.au/how-we-regulate/ingredients-and-scheduling-medicines-and-chemicals/poisons-standard-and-scheduling-medicines-and-chemicals/poisons-standard-susmp.

Current professional authorities for pharmacists and registered nurses

Under the Regulations, authorities for pharmacists and registered nurses, who are not also nurse practitioners, in relation to Schedule 4 (S4, prescription only) and Schedule 8 (S8, controlled drugs) medicines are shown in the following table.

Table 2: Professional authorities for Schedule 4 and Schedule 8 medicines

Health practitioner	Possess	Administer	Supply^	Dispense	Prescribe
Pharmacist	✓	✓	✓	✓	×
Registered nurse[#]	✓	✓	✓*	×	×

[^]Structured Administration and Supply Arrangement (SASA) required

[#]Who is not a nurse practitioner

*Schedule 4 only

Pharmacists can dispense medicines in S4 and S8 once they have received a prescription issued by a health professional with prescribing rights. Similarly, in the hospital setting, doses of S4 and S8 medicines can be administered to patients once an authorised prescriber has written or approved an order on a medication chart.

In the Act and Regulations, the term ‘dispense’ relates to the act of supply following receipt of a prescription. The legislation does not consider direct supply to a patient, by the prescribing health practitioner, as ‘dispensing’. Only pharmacists are authorised to ‘dispense’.

Pharmacists can only independently initiate administration or supply of a S4 or S8 medicine to a patient where there is a Structured Administration and Supply Arrangement (SASA) in place. Similarly, registered nurses can only initiate administration of a S4 or S8 medicine or initiate supply of a S4 medicine under a SASA.

SASAs can only be issued for acute care or for public health programs, such as vaccination. Department of Health issued SASAs include SASAs which authorise:

- Pharmacists to:
    - administer doses of vaccines on the WA Immunisation Schedule
    - supply a patient with a short course of specific antibiotics for the treatment of uncomplicated urinary tract infections
- Registered nurses to:
    - administer doses of vaccines on the WA Immunisation Schedule
    - supply certain S4 medicines, from remote area nursing services, for the treatment of defined acute health conditions.

SASAs cannot be used to authorise a health professional to issue a prescription, for dispensing by a pharmacist.

Pharmacists are authorised to independently supply medicines in Schedule 2 (S2, pharmacy medicine) and Schedule 3 (S3, pharmacist only medicine). Registered nurses can only supply S2 and S3 medicines where a relevant SASA exists and at certain remote medical clinics, where no community pharmacy service is available.

For some classes of health practitioner, endorsement of individual practitioners for scheduled medicines, via their respective national Board, indicates the health practitioner is considered

qualified to prescribe the medicines for which they hold endorsement. For each class of health practitioner currently holding this type of endorsement, the Regulations provide the *authority* for these health practitioners to prescribe in line with their endorsement.

In October 2019, the Pharmacy Board of Australia issued a position statement on pharmacist prescribing[11]. The Board considered there were no regulatory barriers, in terms of the registration of pharmacists, to prescribe via structured prescribing arrangements or under supervision within a collaborative healthcare environment. However, the Board acknowledged that prescribing under these models would require changes in state and territory medicines and poisons legislation to authorise pharmacists to prescribe.

On 17 September 2025, the Pharmacy Board issued a media release stating they had begun work to establish an endorsement for scheduled medicines for pharmacists, to support a consistent, safe, and nationally coordinated approach to pharmacist prescribing[12].

Current non-medical prescribing in Western Australia

The Regulations currently include authority for nurse practitioners, endorsed podiatrists, endorsed optometrists and endorsed midwives to prescribe. All these types of health practitioner have an 'endorsement' on their registration, as a health practitioner, indicating they are considered *qualified* to prescribe. Their prescribing *authority* under the Regulations aligns with the endorsement on their registration and in all cases is limited to prescribing 'in the lawful practice of their profession'.

Currently, both endorsed podiatrists and endorsed optometrists can only prescribe from a defined list of medicines developed by their respective registration Boards. The Optometry Board of Australia is currently reviewing the registration standard for endorsement for scheduled medicines for optometrists, including considering expanding the list of medicines to include oral medicines.

Nurse practitioners and endorsed midwives do not have a specific formulary and prescribe within their profession-related, and personal, scope of practice.

[11] Available at: https://www.pharmacyboard.gov.au/news/professional-practice-issues/pharmacist-prescribing-position-statement.aspx
[12] Available at: https://www.pharmacyboard.gov.au/News/2025-09-17-Endorsement-for-scheduled-medicines.aspx

Consultation responses and recommendations

Demographics

Key stakeholders were emailed an invitation to participate in the consultation. Stakeholder groups included organisations representing the medical, dental, nursing and midwifery and pharmacy professions, relevant health practitioner registration boards, WA Health Service Providers (public hospitals), major private hospitals, tertiary education providers, professional indemnity insurers and health consumer organisations.

The consultation was available on the Department of Health's public consultation hub (https://consultation.health.wa.gov.au/) for a period of 8 weeks, from 5 December 2025 to 2 February 2026. People other than the invited key stakeholders could also respond to the consultation.

The consultation survey questions are available within the Consultation discussion paper: Prescribing by pharmacists and registered nurses[13], which is available on the Department's public consultation hub.

A total of 51 responses were received, with 17 (33.3%) from organisations and 34 (66.7%) from individuals. All individual responses were from registered health practitioners.

Respondents could answer as many questions as they wished. This means the number of respondents answering each question may be less than 51. For example, there were 43 responses to the question about which regulatory option they supported for prescribing by designated registered nurse prescribers (Question 1.1) and 47 responses to the equivalent question in relation to prescribing by pharmacists (Question 4.1).

[13] Available at: https://consultation.health.wa.gov.au/medicines-and-poisons-regulation-branch/prescribing-by-registered-nurses-and-pharmacists/supporting_documents/consultation-discussion-paper-prescribing-by-pharmacists-and-registered-nurses-december-2025pdf

Figure 1: Type of respondent – Organisation

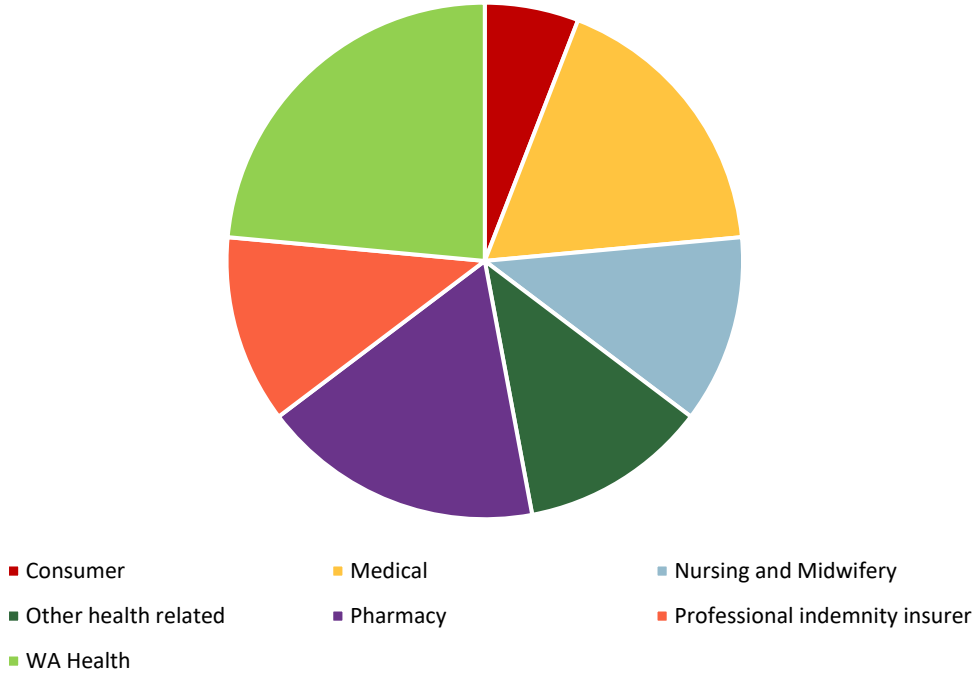
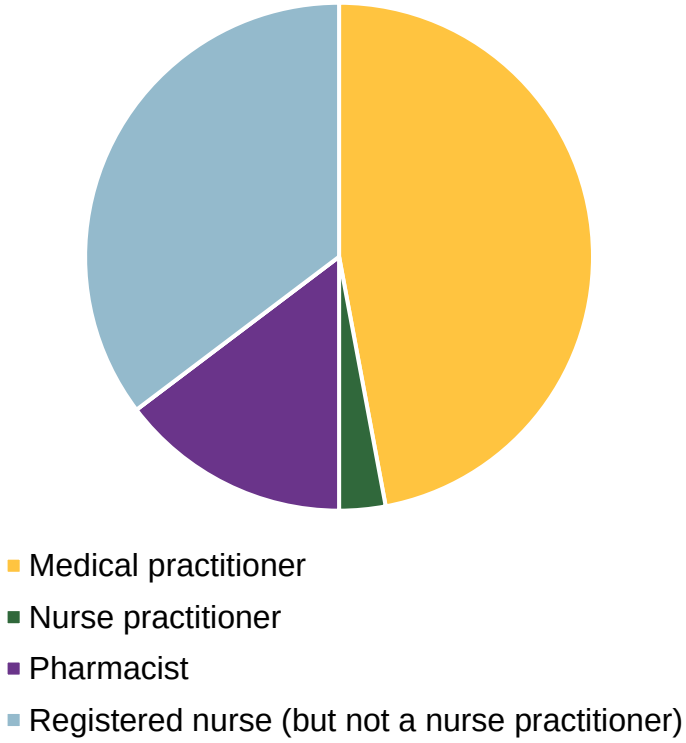


Figure 2: Type of respondent – Individual



Prescribing by designated registered nurse prescribers (DRNP)

DRNP: Regulatory options for prescribing Schedule 4 and Schedule 8 medicines

Designated registered nurse prescribers will be endorsed for scheduled medicines by the NMBA, which means the NMBA considers these registered nurses qualified to prescribe these medicines.

Unlike all other current health practitioner endorsements for scheduled medicines, where endorsed health practitioners are considered qualified to prescribe independently, the NMBA Registration Standard limits DRNP endorsement to collaborative prescribing. The DRNP must have a formal prescribing agreement with a health practitioner with independent prescribing rights and the prescribing agreement must be approved by the relevant health organisation/service or employer.

Consultation respondents were asked to choose their preferred option from the following four regulatory options:

Regulatory Option 1 (status quo): No change, designated registered nurse prescribers are not authorised to prescribe in WA.

Regulatory Option 2: Authorise in a similar way as other health practitioner classes who hold an endorsement for scheduled medicines, by allowing designated registered nurse prescribers to prescribe in line with the requirements of their registration board.

Regulatory Option 3: Authorise designated registered nurse prescribers to prescribe but detail specific requirements within the Regulations.

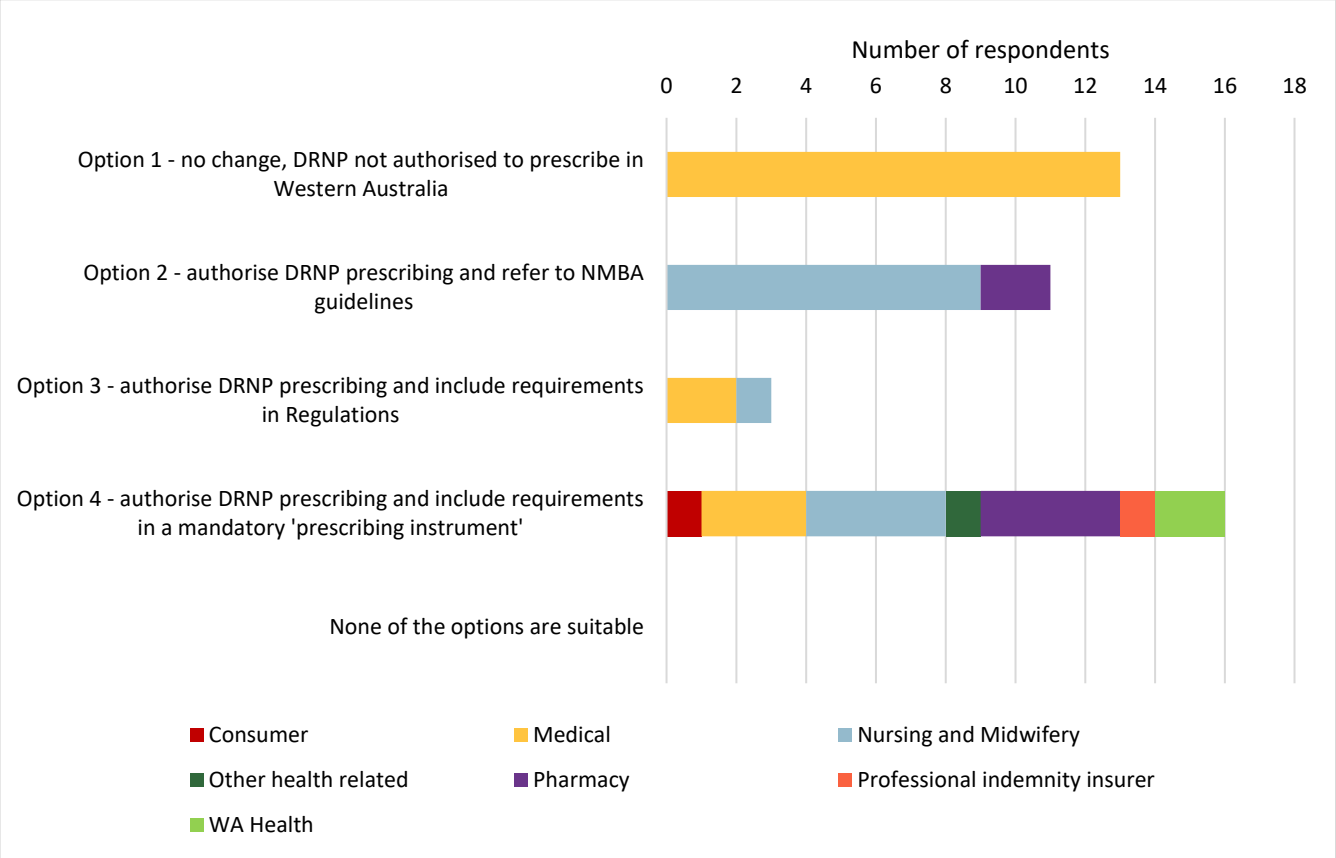
Regulatory Option 4 (Department's preferred option): Authorise designated registered nurse prescribers to prescribe and require that prescribing to be in accordance with a 'prescribing instrument'.

In line with other approvals under the Act and Regulations, a prescribing instrument would be approved by the Chief Executive Officer of the Department of Health (CEO) or their delegate.

As a regulatory instrument, a prescribing instrument could only include requirements considered essential for ensuring safe prescribing.

Any prescribing instrument would be published on the Department's website.

Figure 3: Preferred regulatory option for prescribing by designated registered nurse prescribers (DRNP)



A number of themes emerged in responses from those who did not support DRNP being authorised to prescribe in Western Australia, including:

- Concerns about level and depth of training, particularly in comparison to medical practitioners.
- Potential for fragmentation of care.
- Less ability to follow-up and monitor patients compared to medical practitioners.
- Concerns that these prescribers will be treating symptoms rather than undertaking a comprehensive differential diagnosis and developing holistic management plans.
- Risk of overprescribing, which could result in adverse outcomes, increased diversion of high-risk drugs and higher healthcare costs.

The information provided by some respondents was indicative of them being unaware that DRNP are only considered to be qualified to prescribe as part of a partnership with an autonomous prescriber, in accordance with a written prescribing agreement.

Comments made by those who supported amendment of the Regulations to include prescribing rights for DRNP and also supported a mandatory Prescribing Instrument included:

- Option 4 provides greater flexibility and responsiveness compared to embedding detailed requirements in the Regulations. This was considered important to allow adaption as clinical practice evolves and nurse prescribing matures.
- A Prescribing Instrument can ensure governance and safety standards remain robust.

- Any requirements included in the proposed Prescribing Instrument should not extend beyond those required for safe prescribing, otherwise there is risk of introducing unnecessary artificial barriers.
- Requirements already included in the NMBA Guidelines should not be replicated in the Prescribing Instrument.
- The proposed elements of the Prescribing Instrument are comparable to the framework that has been successfully used in the UK. Under this framework, non-medical prescribers are able to prescribe safely and appropriately within a defined scope of practice.

Recommendation 1

Regulatory Option 4 had the most support and, as the Department's preferred option, it is recommended that the Medicines and Poisons Regulations 2016 be amended to allow designated registered nurse prescribers to prescribe Schedule 4 and Schedule 8 medicines, in accordance with a Prescribing Instrument.

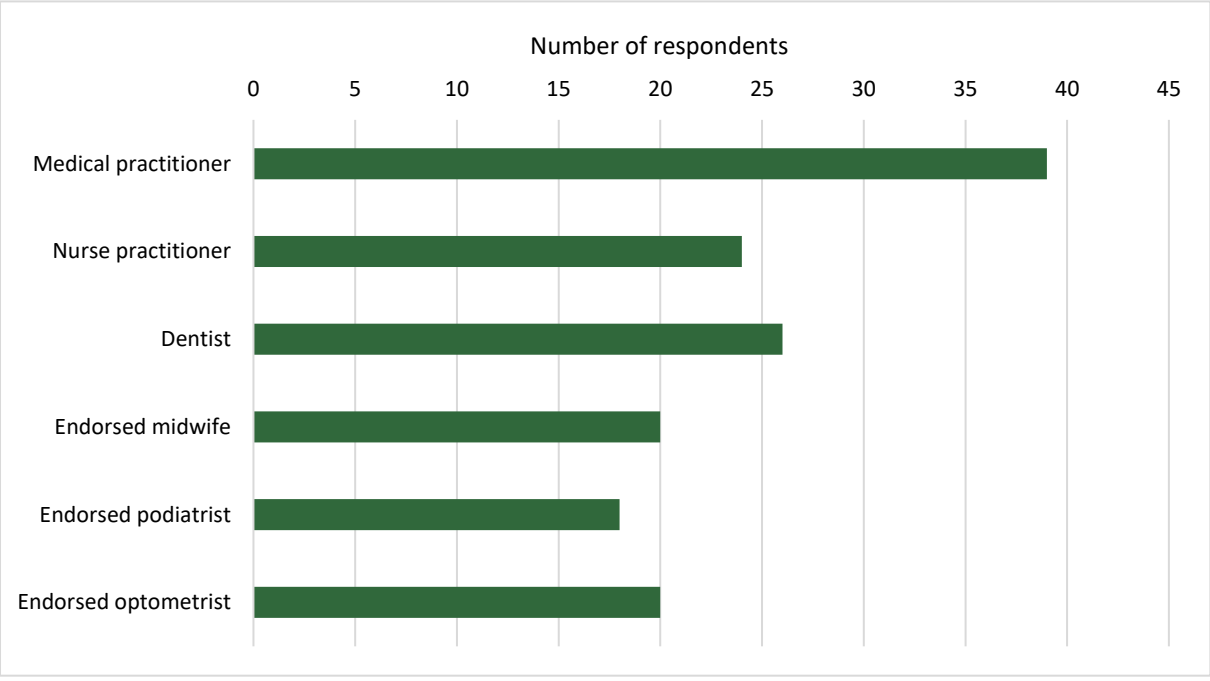
The Prescribing Instrument is to be approved by the Chief Executive Officer of the Department of Health (or their delegate) and is to be published on the Department of Health's website.

DRNP: type of collaborating prescriber

Neither the NMBA Registration Standard nor the NMBA Guidelines limit which type of autonomous prescriber can enter into a prescribing agreement with a DRNP. The examples of autonomous prescribers included in the NMBA Guidelines are medical practitioners and nurse practitioners.

The consultation sought views on which health practitioners with prescribing rights should be able to enter into a prescribing agreement with a DRNP.

Figure 4: Type of autonomous prescriber allowed to have agreement with DRNP



Those who only supported medical practitioners and, in some cases, also dentists, of having collaborative prescribing agreements with DRNP had a number of concerns about allowing prescribing agreements with other prescribers with more narrow scope of practice, including:

- Endorsed midwives, podiatrists and optometrists not having sufficient prescribing experience to mentor and collaborate with a DRNP.
- Only medical practitioners and dentists have the full suite of diagnostic skills to allow correct diagnosis which flows on to appropriate prescribing.
- Restricted formularies available to various health practitioner classes with endorsement for scheduled medicines.
- Only more senior medical practitioners should be able to enter into these type of prescribing agreements, not junior medical officers.
- Concern that the collaborating practitioners may be expected to take responsibility for errors by the DRNP.

Some responses indicated a misunderstanding that a collaborative prescribing agreement could not go beyond the scope of practice of the autonomous prescriber. In other words, an agreement between an endorsed non-medical prescriber and a DRNP cannot allow the DRNP to prescribe medicines that could not also be prescribed by their collaborating prescriber. The NMBA Guidelines already state: The authorised health practitioner must be aware of the designated RN prescriber's scope of practice with regards to prescribing and ensure their scope and area of practice align with the designated RN prescriber's scope of prescribing.

Recommendation 2

- Do not amend the Medicines and Poisons Regulations 2016 to limit which autonomous prescribers can have a prescribing agreement with a designated registered nurse prescriber.
- Include an explicit statement in the Prescribing Instrument that the prescribing agreement cannot allow the designated registered nurse prescriber to prescribe any medicines that the collaborating autonomous prescriber is not also authorised to prescribe.

DRNP: Schedule 8 prescribing

DRNP are considered by the NMBA to be qualified to prescribe Schedule 8 (S8) medicines, when prescribing in partnership with an autonomous prescriber, in accordance with a formal prescribing agreement. In addition, the NMBA requirements mean the prescribing agreement must be approved by the health organisation/service or employer of the DRNP.

The expectation is that the governance framework used by the approving health organisation/service or employer, to enable prescribing agreements, would include assessment for prescribing of high-risk medicines, including, but not limited to, S8 medicines, other medicines monitored by ScriptCheckWA, chemotherapy agents and potassium and other electrolytes.

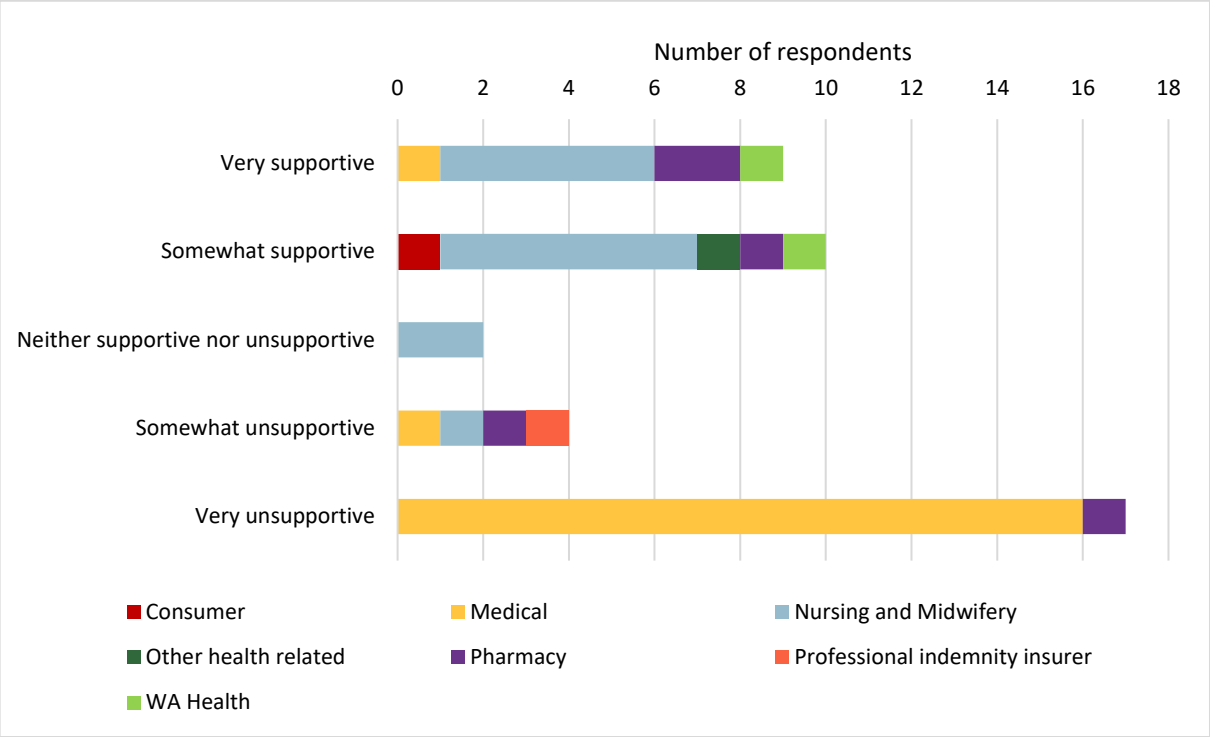
Regardless of any requirements within the DRNP's prescribing agreement, compliance with all parts of the Act and Regulations in relation to prescribing would be mandatory. For

example, prescribing of S4 monitored medicines and S8 medicines would need to be in accordance with the Monitored Medicines Prescribing Code.[14]

As DRNP will always be working in partnership with an autonomous prescriber, such as a medical practitioner or nurse practitioner, the autonomous prescriber could decide that they did not wish to include prescribing of any Schedule 8 medicines within the prescribing agreement or could institute specific restrictions on the prescribing of this class of medicines through the prescribing agreement.

The consultation sought information about the degree of support for DRNP prescribing S8 medicines and also asked respondents whether certain factors would change their opinion about whether DRNP should be authorised to prescribe S8 medicines. Forty two respondents indicated their level of support for DRNP prescribing S8 medicines.

Figure 5: Support for DRNP prescribing Schedule 8 medicines



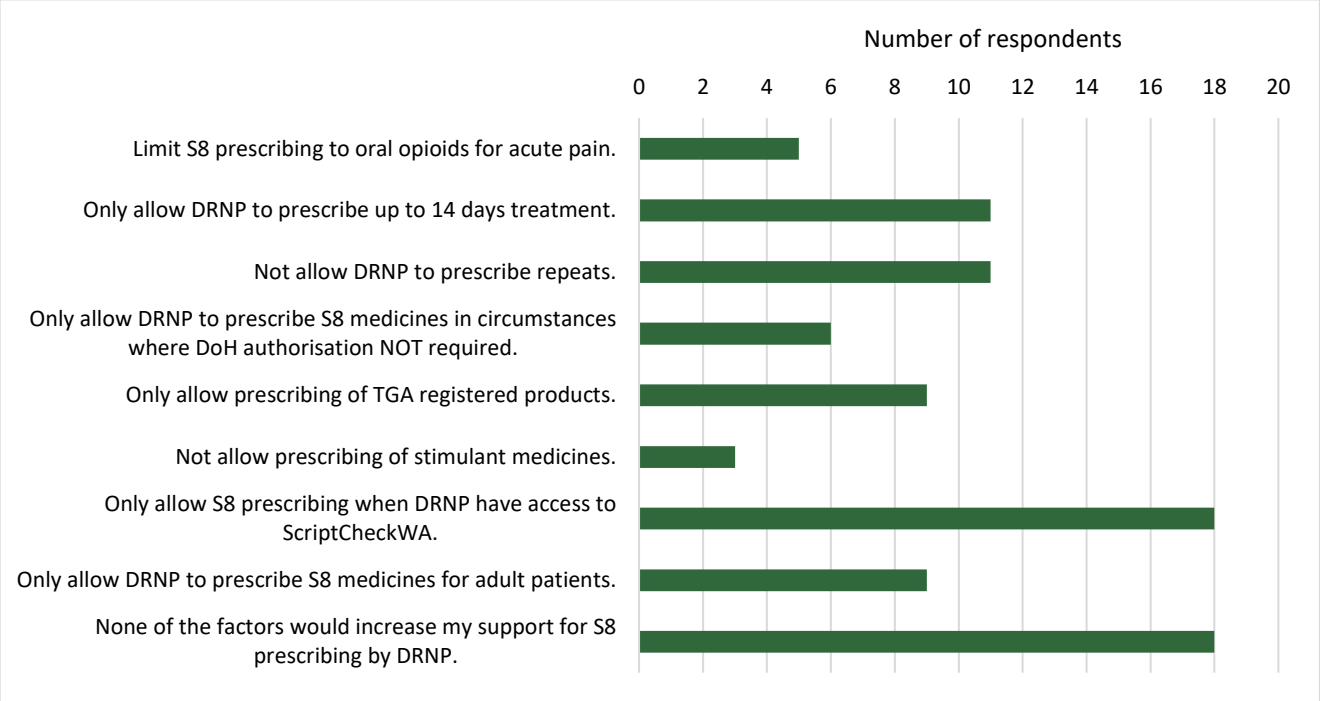
Respondents who stated they were either ‘somewhat unsupportive’ or ‘very unsupportive’ provided various reasons for this choice:

- Concern that level of training would not adequately equip DRNP to prescribe these high-risk medicines.
- Personal experience of inappropriate prescribing of S8 medicines by other currently authorised non-medical prescribers.
- Concerns about unsafe prescribing, with increased risk of overdose and diversion.
- Allowing even more classes of health professional to prescribe these medicines is risky, particularly in light of the opioid crisis.
- Use of S8 medicines should be limited and further avenues for access should not be provided.

[14] Available at: https://www.health.wa.gov.au/~/media/Corp/Documents/Health-for/Medicines-and-Poisons/PDF/Monitored-Medicines-Prescribing-Code.pdf

- DRNP should undertake further Alcohol and Other Drugs (AOD) specific education to strengthen their expertise.
- Lack of access to ScriptCheckWA for DRNP is a significant barrier to safe prescribing of S8 medicines.

Figure 6: Factors that may increase support for DRNP prescribing Schedule 8 medicines



Other suggestions for managing risks, made by respondents, included:

- Restricting DRNP S8 prescribing to continuation of treatment commenced by the autonomous prescriber.
- Requiring the DRNP to have the authorisation of the autonomous prescriber, on a ‘case by case’ basis, prior to issuing a prescription for a S8 medicine.

Currently, a barrier exists to DRNP from accessing ScriptCheckWA, WA’s real-time prescription monitoring (RTPM) system. All states and territories are working with the national RTPM vendor to activate enhancements to the jurisdictional RTPM systems to allow access by DRNP. As Figure 6 shows, there was strong support for access to ScriptCheckWA being a pre-requisite for prescribing S8 medicines. Registration with ScriptCheckWA is mandatory for current prescribers of monitored medicines through Regulation 22A.

Until such time as ScriptCheckWA is available to DRNP, it is considered reasonable to restrict the prescribing of monitored medicines by DRNP to situations where these medicines will not be under the direct control of the patient. Examples include: hospital inpatients, people living in residential care facilities and people in custodial settings. This can be managed using the Monitored Medicines Prescribing Code until access to ScriptCheckWA has been granted.

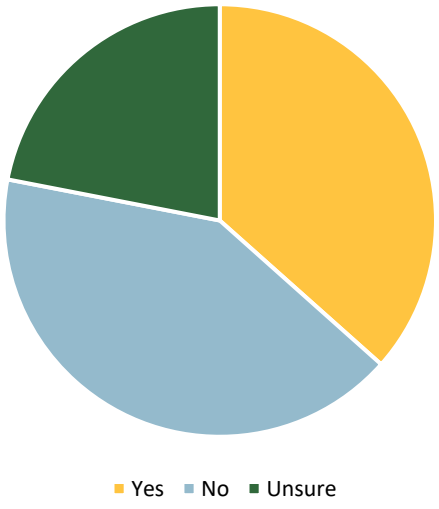
Recommendation 3

- Include Schedule 8 medicines in the amendment to allow prescribing by designated registered nurse prescribers.
- Include a requirement in the Prescribing Instrument that prescribing agreements for designated registered nurse prescribers must include clear detail of what is agreed in relation to the prescribing of Schedule 4 monitored medicines and Schedule 8 medicines.
- Amend the Medicines and Poisons Regulations 2016 to include designated registered nurse prescriber as a relevant health professional under Regulation 22A, with the implementation date aligned with the date of inclusion as a prescriber class by ScriptCheckWA.
- This is consistent with the regulatory requirements for other currently authorised prescribers.
- Undertake further targeted consultation on whether amendments to the Monitored Medicines Prescribing Code are required to ensure safe prescribing of Schedule 8 medicines by designated registered nurse prescribers.

DRNP: Direct supply of Schedule 4 and Schedule 8 medicines

Forty-one respondents answered the question about whether designated registered nurse prescribers should be able to also directly supply their patient with the same S4 and S8 medicines for which they could issue a prescription.

Figure 7: Direct supply of Schedule 4 and Schedule 8 medicines by DRNP



Respondents who said that DRNP should not be able to make a direct supply of S4 or S8 medicines gave a number of reasons for this:

- Do not support any prescribing or supply of S4 or S8 medicines by DRNP.
- Direct supply removes important safety checks within the medication management chain.
- Dispensing by a pharmacist rather than direct supply provides an additional layer of assurance that the medicine is safe and appropriate for the patient.

- Concerns about conflict of interest with the prescriber and the supplier being the same health practitioner.

The Regulations allow all currently authorised prescribers, including medical practitioners, dentists and non-medical prescribers, to supply their patient with a quantity of the same medicines for which they could issue a prescription. When supplying S4 or S8 medicines, the Regulations require these prescribers to keep a detailed record of supply and label the product in a similar manner to when a prescription medicine is dispensed at a pharmacy.

Although it is not common for prescribers to make a direct supply rather than issuing a prescription, for dispensing by a pharmacist, this may occur in situations such as: where there is no pharmacy that is readily accessible by the patient, in urgent care settings where commencement of treatment is an imperative or where a niche treatment is being prescribed. Examples include: supply from a nurse-led remote area clinic, supply for treatment of a sexually transmitted infection or supply of various medicines in anticipation of overseas travel when a person is also being administered vaccines for travel at the clinic.

The NMBA Guidelines indicate that separation of prescribing and supply/dispensing is preferable as it results in additional checks to safeguard patients and, additionally, harnesses the particular expertise of the pharmacist.

The Australian Parliament already has a bill before it to enable designated registered nurse prescribers to prescribe under the Pharmaceutical Benefits Scheme (PBS)[15]. This will allow the patient to have their DRNP issued prescription dispensed at a pharmacy at the same cost as when their prescription is issued by other PBS prescribers, such as medical practitioners and nurse practitioners.

Recommendation 4

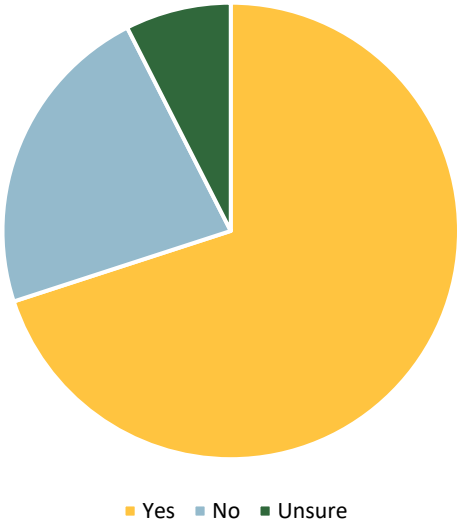
- Amend the Medicines and Poisons Regulations 2016 to allow designated registered nurse prescribers to supply the same medicines they are authorised to prescribe.
- This is consistent with the regulatory requirements for other currently authorised prescribers.
- As with other authorised prescribers, professional practice considerations will inform the situations where an individual prescriber considers it is appropriate to make a direct supply.

DRNP: Supply of Schedule 2 and Schedule 3 medicines

Forty respondents answered the question about whether designated registered nurse prescribers should be allowed to supply medicines in Schedule 2 (S2) and Schedule 3 (S3). These are medicines that can be supplied ‘over the counter’ in pharmacies and which currently authorised prescribers can also supply to their patients without a prescription.

[15] Available at: https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/bd/bd2526/26bd036

Figure 8: Supply of Schedule 2 and Schedule 3 medicines by DRNP



Reasons given by respondents who said that DRNP should not be able to supply S2 or S3 medicines included:

- DRNP have different training to pharmacists and will not necessarily have the same level of expertise in selecting and counselling about the use of S2 and S3 medicines.
- Although lower risk than S4 and S8 medicines, S2 and S3 medicines still carry meaningful clinical risks.
- Poor outcomes can occur following the supply of S2 and S3 medicines by pharmacists and this may be increased by allowing other health practitioners to also supply these medicines.
- There was support for supply of S2, but not S3, medicines by DRNP.

The NMBA Registration standard states that DRNP are qualified to administer, obtain, possess, prescribe, supply and/or use medicines in S2, S3, S4 and S8. The Medicines and Poisons Act only requires a prescription to be issued for medicines in S4 and S8.

It would be inappropriate to mandate that a DRNP issue a prescription to direct pharmacists to supply a medicine in S2 or S3, because pharmacists already have a professional authority to supply these schedules of medicines.

Despite the Regulations not requiring a prescription for S2 and S3 medicines, that does not preclude a DRNP choosing to issue a prescription, as a way of communicating their management plan to the supplying pharmacist. As with any supply of a scheduled medicine, the pharmacist must exercise their professional responsibility and this could include contacting the DRNP, if they have any concerns about the requested supply.

Under the Act, other authorised prescribers can make a direct supply of a S2 or S3 medicines, provided they are acting in the lawful practice of their profession. Pharmacists, when working in a registered pharmacy business, can supply these medicines as retail items, including having the medicines on display for sale. Other health practitioners would only be able to supply these medicines as part of a consultation with the patient.

Recommendation 5

- Amend the Medicines and Poisons Regulations 2016 to allow designated registered nurse prescribers to supply Schedule 2 and Schedule 3 medicines, in the lawful practice of their profession.
- This is consistent with the regulatory requirements for other currently authorised prescribers.

DRNP: Content of Prescribing Instrument

Twenty respondents provided qualitative information relating to what they thought should, or should not, be included in a Prescribing Instrument.

There was concern expressed by a number of respondents that by having a Prescribing Instrument there was potential to create barriers to prescribing over and above the requirements of the NMBA Guidelines. In addition, duplication of the requirements of the NMBA Guidelines within a Prescribing Instrument was considered unnecessary and could create a burden for both the Department and practitioner(s) without providing additional protection to the public.

Other respondents felt a Prescribing Instrument would ensure there were robust governance and safety standards, while allowing adaptation as DRNP practice evolves and matures.

Suggestions for additional information to be included in a Prescribing Instrument included:

- A maximum review period whereby the DRNP and the autonomous prescriber review their agreement and have it re-approved by their employing/contracting health organisation/service or employer.
- A requirement for DRNP to have access to ScriptCheckWA.
- The employer approving the prescribing agreement must not be the same person as the authorising autonomous prescriber.
- Telehealth options need to be allowable under any Prescribing Instrument.
- Organisational prescribing governance frameworks should include an escalation pathway for adverse events.
- Prescribers should be required to provide written patient information for high-risk medicines.

Recommendation 6

- The proposed Prescribing Instrument is intended to mandate requirements necessary to protect public health, by managing risks associated with the prescribing and supply of Schedule 4 and Schedule 8 medicines by DRNP.
- Risk management strategies proposed for inclusion in the Prescribing Instrument are:
    - The DRNP must have a written prescribing agreement with one or more authorising autonomous prescribers, who are employed by, or contracted to, the same organisation/service in which the DRNP is employed.
    - If the DRNP or the authorising prescriber is no longer employed by, or contracted to, the organisation/service, the prescribing agreement is no longer considered current and cannot be used to authorise prescribing by the DRNP.
    - A clinical governance committee of the DRNP's employing/contracting organisation/service must provide overall oversight and risk management of DRNP prescribing.
    - The DRNP's employing/contracting organisation/service must have mechanisms for incident review and internal audit by a quality and safety team.
    - Prescribing of Schedule 8 and Schedule 4 monitored medicines must be compliant with the requirements of Part 11 of the Medicines and Poisons Regulations 2016.
    - DRNP must only prescribe medicines monitored by ScriptCheckWA if they are registered to use ScriptCheckWA.
- Targeted consultation on the content of the draft Prescribing Instrument is recommended.

Prescribing by pharmacists

Pharmacists: Regulatory options for prescribing Schedule 4 and Schedule 8 medicines

Unlike other health practitioner classes, who are already considered qualified to prescribe by their national registration Board via an endorsement for scheduled medicines, the Pharmacy Board of Australia has only announced they will be pursuing an endorsement process to support pharmacist prescribing in September 2025.

In 2019, the Board announced they considered there were no regulatory barriers, in terms of the registration of pharmacists, to prescribe via structured prescribing arrangements or under supervision within a collaborative healthcare environment. However, the Board acknowledged that prescribing under these models would require changes in state and territory medicines and poisons legislation to authorise pharmacists to prescribe. The Board also stated their view was that autonomous prescribing would require additional regulation, under the Health Practitioner National Law, via an endorsement for scheduled medicines.

As an endorsement for scheduled medicines for pharmacists is still under development, any authorisation for pharmacist to prescribe, via the Medicines and Poisons Regulations 2016, must include the detail necessary to set the boundaries to keep patients and the broader public safe.

Two models of care, which will require pharmacists to prescribe, are currently under development in Western Australia:

1. The Enhanced Access Community Pharmacy Pilot (EACPP) and
2. Collaborative Pharmacist Medication Prescribing (CPMP).

Consultation respondents were asked to choose their preferred option from the following three regulatory options:

Regulatory Option 1 (status quo): No change, pharmacists are not authorised to prescribe in WA.

Regulatory Option 2: Authorise pharmacists to prescribe and detail specific requirements within the Regulations.

The specific requirements would depend on the prescribing model with which the pharmacist is involved. For example, regulatory requirements for the EACPP could include:

- Pharmacists must successfully complete an education program approved by the Department of Health.
- Pharmacists must only issue prescriptions when practising in a setting that meets the EACPP consultation room requirements.
- Pharmacists must prescribe in accordance with the EACPP clinical guidelines and protocols.

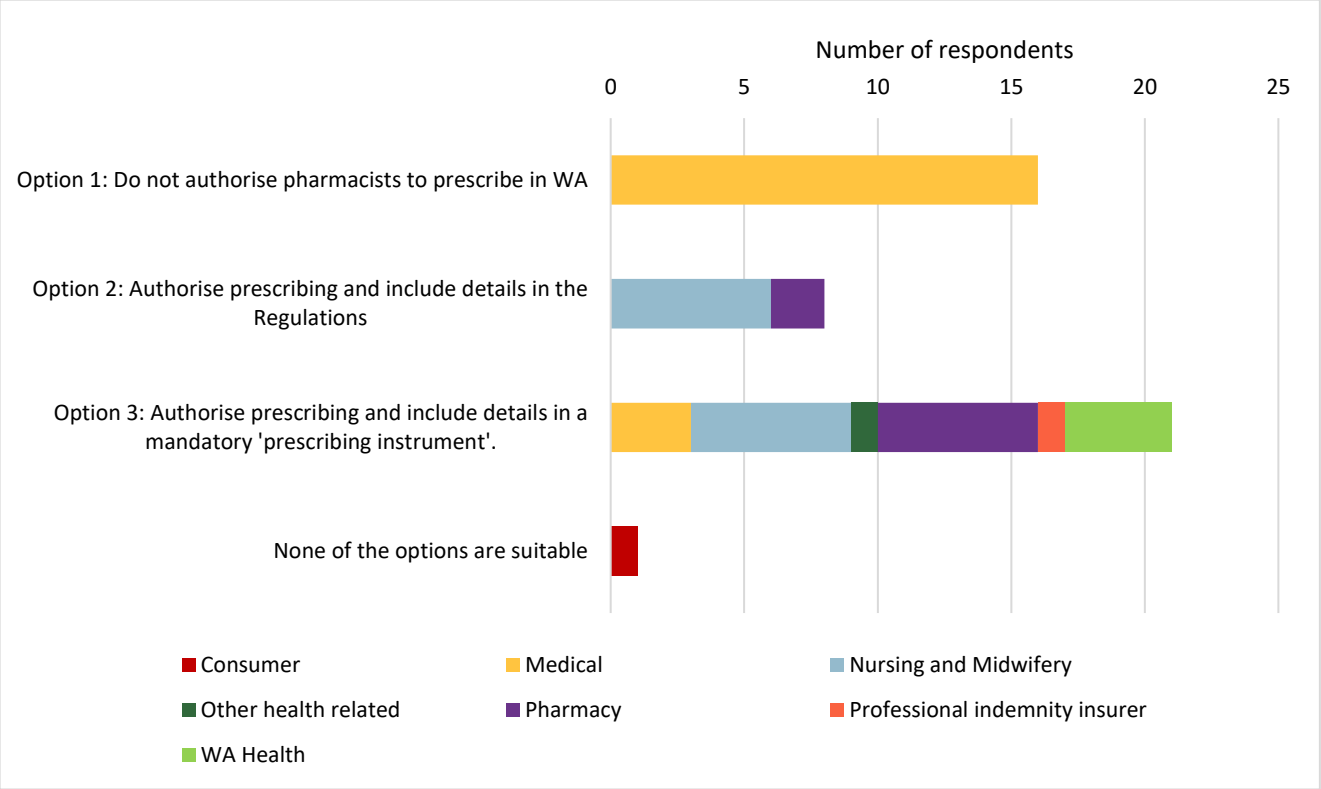
A separate, and different, set of regulatory requirements would be needed for hospital-based CPMP. For example, a regulatory framework for governance over prescribing agreements would be required.

Inclusion of this detail within the Regulations themselves is not the preferred option, as the future development of pharmacist prescribing, including via a Pharmacy Board endorsement, would not be adequately supported without further amendment of the Regulations.

Regulatory Option 3: Authorise pharmacists to prescribe and require that prescribing be in accordance with a 'prescribing instrument'.

Information included in a prescribing instrument would be similar to the requirements described in Option 2. This is the preferred option, as a prescribing instrument can be more responsive to the development of pharmacist prescribing, as this practice matures over time.

Figure 9: Preferred regulatory option for prescribing by pharmacists



The main reason provided by respondents for supporting the use of a mandatory Prescribing Instrument was that, as prescribing by pharmacists is evolving, with the Board recently announcing they are progressing an endorsement for scheduled medicines for pharmacists, a Prescribing Instrument provides the necessary flexibility that cannot be provided by regulations alone. Other reasons for supporting the use of a Prescribing Instrument included:

- Provides consistency across the professions.
- Promotes public confidence and transparency, as it will be published on the Department's website.
- Whilst a Prescribing Instrument is supported, it is important that the requirements are principles-based rather than overly prescriptive, to avoid unintentionally constraining innovation or timely implementation of new prescribing models.

The respondents who did not support prescribing by pharmacists were the same respondents who did not support prescribing by DRNP.

Respondents who did not support the use of a Prescribing Instrument did not support any prescribing by pharmacists. Reasons for not supporting prescribing by pharmacists were

similar to those provided in relation to prescribing by DRNP, including lack of adequate training particularly in relation to diagnosis, lack of access to pathology and other diagnostic tests, inability to regularly follow-up and monitor patients and fragmentation of care.

A significant additional concern was conflict of interest due to the risk of pharmacists practising within community pharmacies being both the prescriber and dispenser of the medicines. The fact that community pharmacists could be the diagnostician, prescriber and supplier of the medicine was suggested as creating financial incentives that could adversely influence clinical decision making.

The majority of responses that were unsupportive of pharmacist prescribing focussed on prescribing by community pharmacists, such as in the EACPP, rather than providing specific feedback on collaborative prescribing models for pharmacists, such as the CPMP project.

Recommendation 7

Regulatory Option 3 had the most support and, as the Department's preferred option, it is recommended that the Medicines and Poisons Regulations 2016 be amended to allow pharmacists to prescribe Schedule 4 and Schedule 8 medicines, in accordance with a Prescribing Instrument.

The Prescribing Instrument is to be approved by the Chief Executive Officer of the Department of Health (or their delegate) and is to be published on the Department of Health's website.

Pharmacists: Schedule 8 prescribing

Of the two current programs under development, where pharmacist prescribing will be needed, only the CPMP may require pharmacists to issue prescriptions for both S4 and S8 medicines. The EACPP will be limited to S4 medicines.

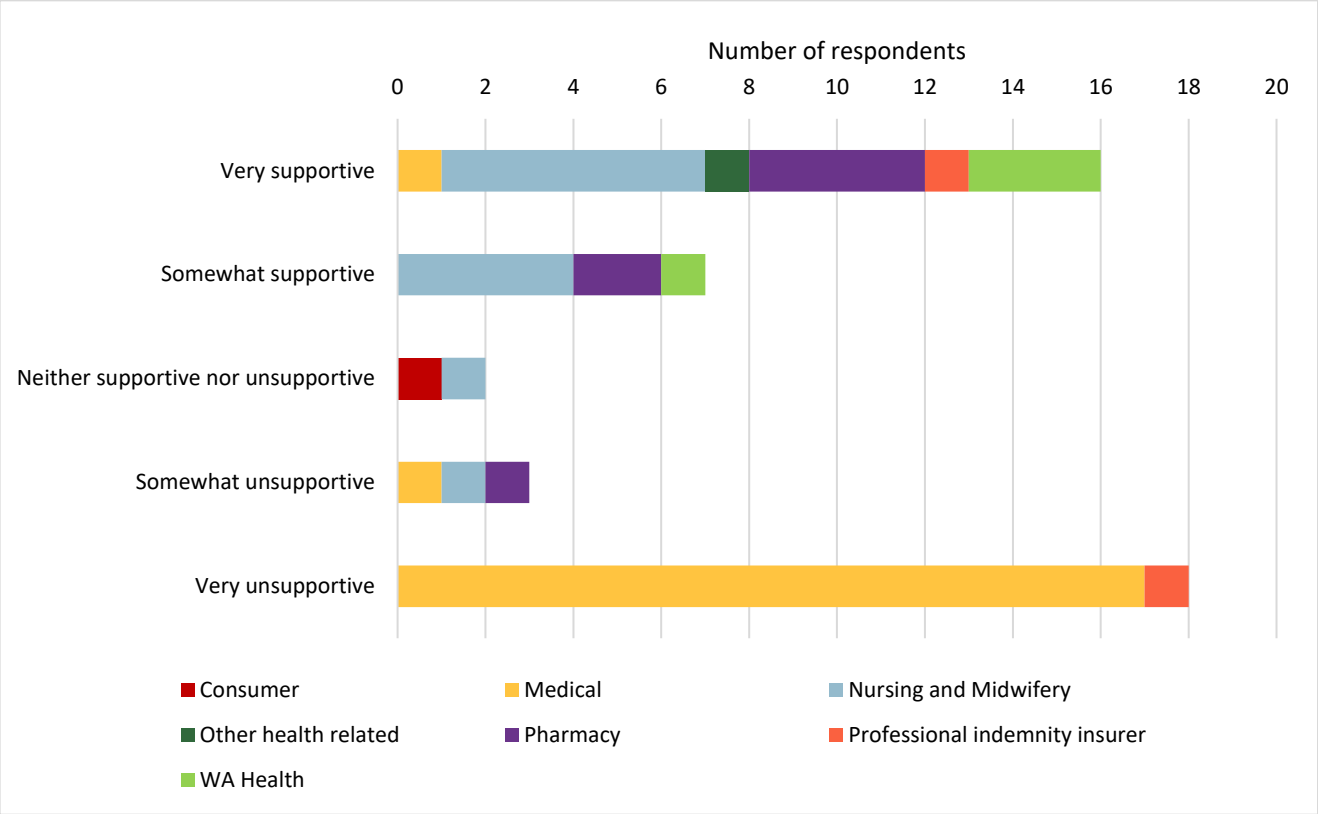
For the CPMP, it is expected that the governance framework used by the employing health organisation/service, will include assessment for prescribing of high-risk medicines, including, but not limited to, S8 medicines, other medicines monitored by ScriptCheckWA, chemotherapy agents and potassium and other electrolytes.

Regardless of any requirements within collaborative prescribing agreements for pharmacists operating within the CPMP, compliance with all parts of the Act and Regulations in relation to prescribing would be mandatory. For example, prescribing of S4 monitored medicines and S8 medicines would need to be in accordance with the Monitored Medicines Prescribing Code.

As with DRNP, because pharmacists will be working collaboratively with the patient's treating medical team, the medical practitioners in this team could choose to exclude S8 medicines from the medicines they allow the pharmacist to prescribe or they could institute specific restrictions on the prescribing of this class of medicines. For example, in the hospital setting, a pharmacist may be able to chart an inpatient medication order for a S8 medicine the patient was already taking on admission to hospital, but may not be authorised to issue discharge prescriptions for S8 medicines.

The consultation sought information about the degree of support for pharmacist prescribing of S8 medicines and also asked respondents whether certain factors would change their opinion about whether pharmacists should be authorised to prescribe S8 medicines. Forty-six respondents indicated their level of support for pharmacists prescribing S8 medicines.

Figure 10: Support for pharmacists prescribing Schedule 8 medicines

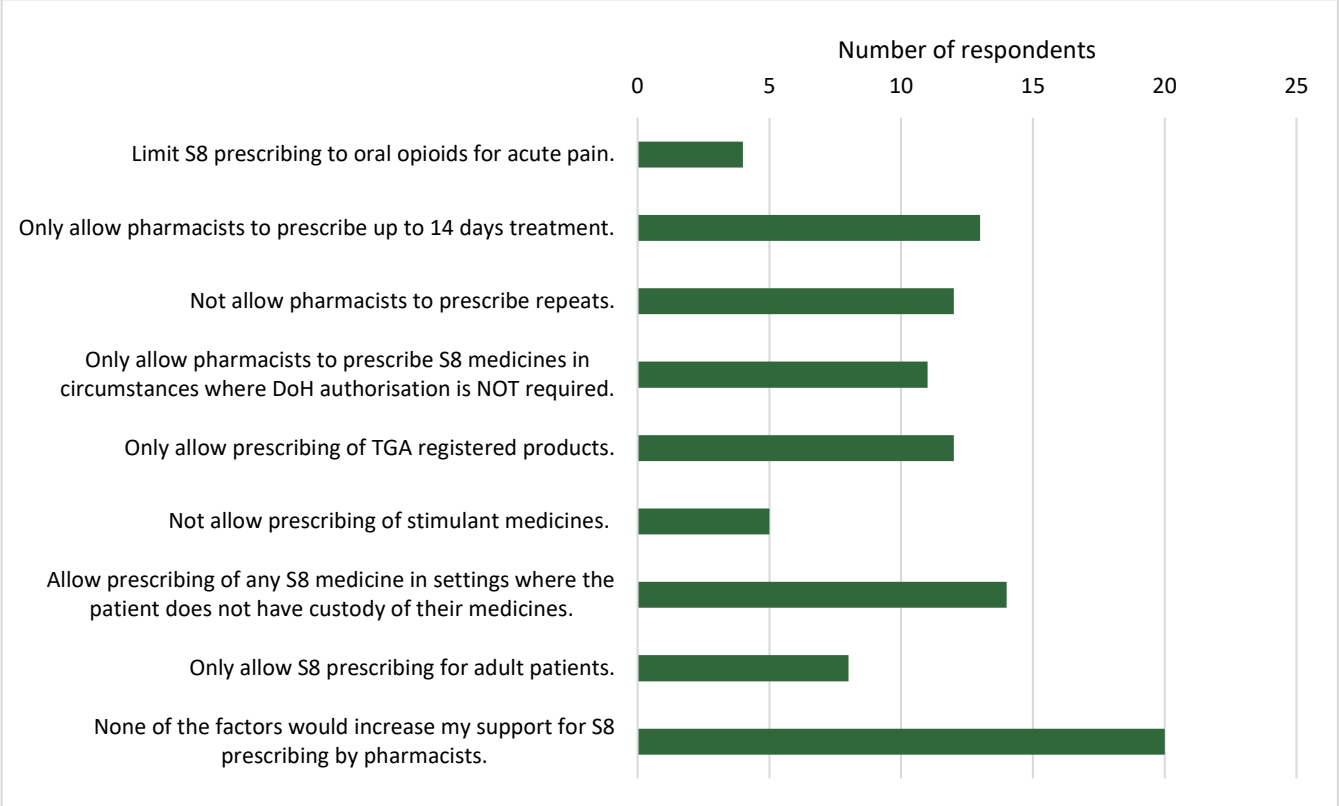


Respondents who stated they were either ‘somewhat unsupportive’ or ‘very unsupportive’ provided various reasons for this choice:

- Concern that level of training would not adequately equip pharmacists to prescribe these high-risk medicines.
- Personal experience of inappropriate prescribing of S8 medicines by other currently authorised non-medical prescribers.
- Concerns about unsafe prescribing, with increased risk of overdose and diversion.
- Allowing even more classes of health professional to prescribe these medicines is risky, particularly in light of the opioid crisis. Further avenues for access should not be provided.

As health practitioners with authority to supply monitored medicines, pharmacists already have full access to ScriptCheckWA.

Figure 11: Factors that may increase support for pharmacists prescribing Schedule 8 medicines



Responses about factors that could increase support for S8 prescribing by pharmacists were similar to the responses to the equivalent question in relation to DRNP prescribing.

Other suggestions for managing risks, made by respondents, included:

- It was noted that S8 prescribing by pharmacists could assist with community support programs in the AOD sector such as the Community Program for Opioid Pharmacotherapy.
- ScriptCheckWA could be used to monitor for separation of prescribing and dispensing.
- Restricting pharmacist S8 prescribing to continuation of treatment commenced by a medical practitioner where there is a documented management plan available.

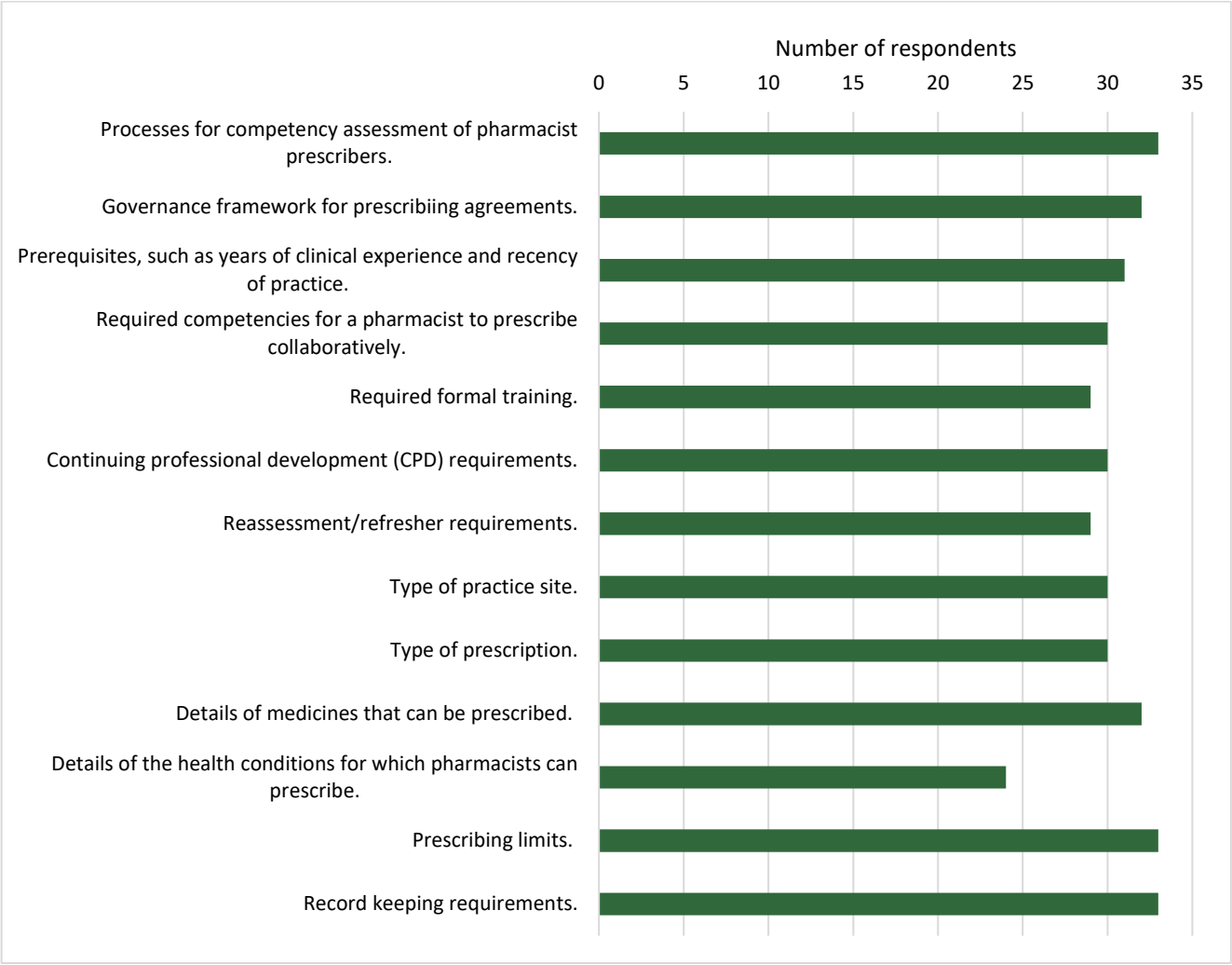
Recommendation 8

- Include Schedule 8 medicines in the amendment to allow prescribing by pharmacists.
- Use the Prescribing Instrument to restrict prescribing of Schedule 8 medicines and Schedule 4 monitored medicines in line with the requirements of the EACPP and CPMP programs.
- Undertake further targeted consultation on potential amendments to the Monitored Medicines Prescribing Code required to ensure safe prescribing of Schedule 8 medicines by pharmacists, particularly in view of the Pharmacy Board of Australia's proposed endorsement of pharmacists for scheduled medicines.

Pharmacists: Collaborative prescribing – prescribing instrument content

Thirty-eight respondents answered the questions about information that should be included in a Prescribing Instrument to support collaborative prescribing by pharmacists.

Figure 12: Requirements for inclusion in Prescribing Instrument



Other information that respondents indicated could be included in a Prescribing Instrument included:

- Requirements for communication with the patient's usual treating medical team.
- Review processes in the event of adverse outcomes.
- Limits on the duration of prescriptions: for example, maximum one month's treatment.
- Separation between prescribing and dispensing.
- Pharmacists participating in collaborative prescribing agreements must not have any applicable restrictions on their registration by the Pharmacy Board of Australia.
- Pharmacists should be able to upload information to MyHealth Record.

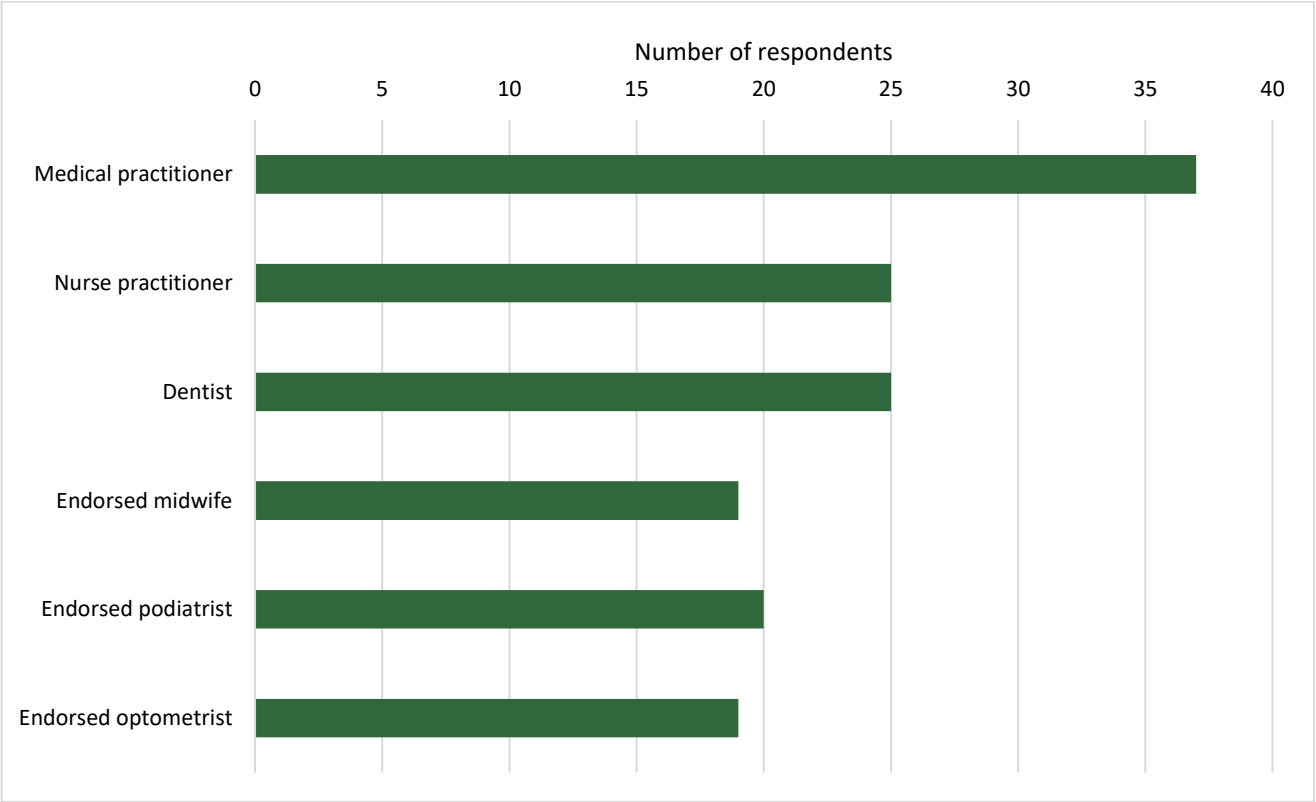
Recommendation 9

- The proposed Prescribing Instrument is intended to mandate requirements necessary to protect public health, by managing risks associated with the prescribing of Schedule 4 and Schedule 8 medicines by pharmacists.
- Risk management strategies proposed for inclusion in the Prescribing Instrument in relation to collaborative pharmacist medication prescribing are:
    - The pharmacist must have a written prescribing agreement with one or more authorising autonomous prescribers, who are employed by, or contracted to, the same organisation/service in which the pharmacist is employed/contracted.
    - The prescribing agreement must be approved by the pharmacist's employing/contracting organisation/service.
    - If the pharmacist or the authorising prescriber is no longer employed by, or contracted to, the organisation/service, the prescribing agreement is no longer considered current and cannot be used to authorise prescribing by the pharmacist.
    - A clinical governance committee of the pharmacist's employing/contracting organisation/service must provide overall oversight and risk management of collaborative prescribing by pharmacists, including processes for:
        - Ensuring that pharmacists participating in collaborative prescribing are, and remain, competent to prescribe.
        - Governance over the content of prescribing agreements.
        - Clinical records of consultations between pharmacists and patients.
        - Approval of collaborative prescribing agreements.
        - Review of collaborative prescribing agreements.
        - Separation of prescribing and dispensing.
    - The pharmacist's employing/contracting organisation/service must have mechanisms for incident review and internal audit by a quality and safety team.
    - Prescribing of Schedule 8 and Schedule 4 monitored medicines must be compliant with the requirements of Part 11 of the Medicines and Poisons Regulations 2016.
    - Pharmacists must only prescribe medicines monitored by ScriptCheckWA if they are registered to use ScriptCheckWA.
- In its first iteration, the Prescribing Instrument should also require pharmacists to comply with materials developed and published as part of the Collaborative Pharmacist Medication Prescribing program.
- Targeted consultation on the content of the Prescribing Instrument is recommended.

Pharmacists: Collaborative prescribing agreements

Thirty-seven responses were received in relation to which autonomous prescribers should be able to enter into collaborative prescribing agreements with pharmacists.

Figure 13: Type of autonomous prescriber allowed to have agreement with pharmacist



Reasons provided by respondents for only selecting certain classes of autonomous prescriber included:

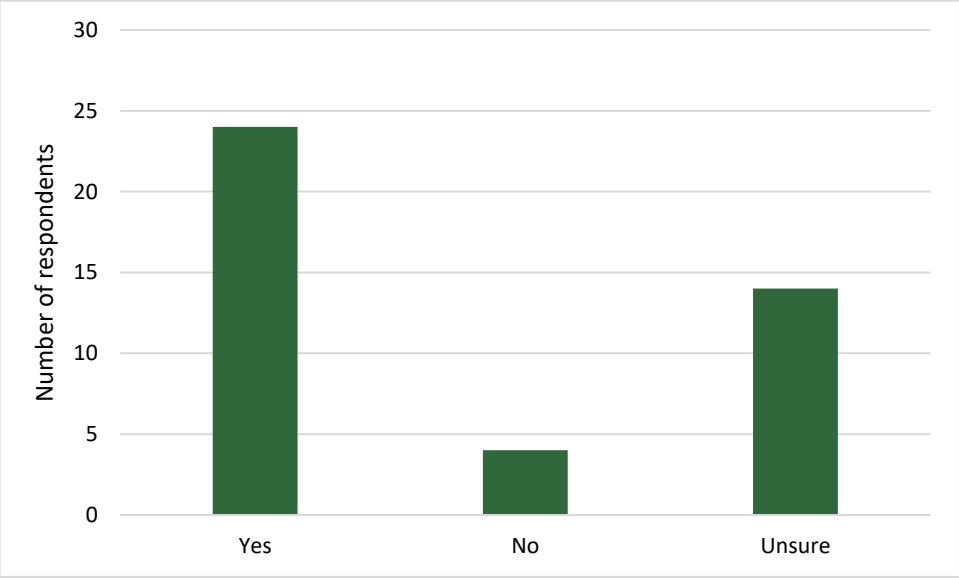
- Endorsed practitioners do not have the experience required in risk mitigation to oversee pharmacist prescribing.
- Medical practitioners are trained and experienced in supervision of clinical decision making at a high level. Other prescriber classes should only be able to supervise if they can demonstrate equivalent skill and training.
- Would only support agreements with nurse practitioners in circumstances where no medical practitioner is available, such as some very remote settings.
- Pharmacists are more likely to be working closely with medical practitioners and nurse practitioners in clinical settings where collaborative prescribing models are applicable.
- Concern that endorsed prescribers, with a narrow scope of practice, cannot provide the necessary safeguards.

Recommendation 10

- Do not use the Medicines and Poisons Regulations 2016, or the proposed Prescribing Instrument, to limit which autonomous prescribers can have a prescribing agreement with a pharmacist.
- Include an explicit statement in the Prescribing Instrument that the prescribing agreement cannot allow the pharmacist to prescribe any medicines that the collaborating autonomous prescriber is not also authorised to prescribe.

There were forty-two responses about whether prescribing agreements for pharmacists should be approved by a hospital's Drug and Therapeutics Committee or an equivalent governance committee.

Figure 14: Approval of prescribing agreements for pharmacists in the hospital setting



Reasons given by those who agreed with approval of prescribing agreements included:

- Essential to ensure robust clinical governance, patient safety and oversight.
- A mechanism to confirm that prescribing agreements are consistent with hospital policies and regulatory requirements.
- Approval by a D&T committee provides clinical governance and oversight, consistency with formulary and policy, a multidisciplinary review and risk mitigation for high-risk medicines.
- Sensible to use existing governance structures.
- Aligns with the requirements for Structured Administration and Supply Arrangements (SASAs).

Reasons for not supporting approval of prescribing agreements included creating a barrier to implementation of collaborative prescribing and concerns that D&T committees may want to limit scope or practice rather than enhancing scope of practice.

Recommendation 11

Include a requirement, in the Prescribing Instrument, that the employing/contracting healthcare organisation/service must have an approval process involving their drug and therapeutics committee, or other clinical governance committee, for collaborative prescribing agreements between pharmacists and autonomous prescribers.

In the hospital setting, different pharmacists may work in the same clinical area either regularly, particularly where extended hours coverage is provided, or to cover leave. This means it may be impractical for a collaborative prescribing agreement to be limited to one pharmacist at a time. However, it would be important for all pharmacists included in a prescribing agreement to not only have demonstrated competency to prescribe but also an appropriate scope of practice for the clinical area in which they would be prescribing.

Figure 15: Individual vs. group prescribing agreements

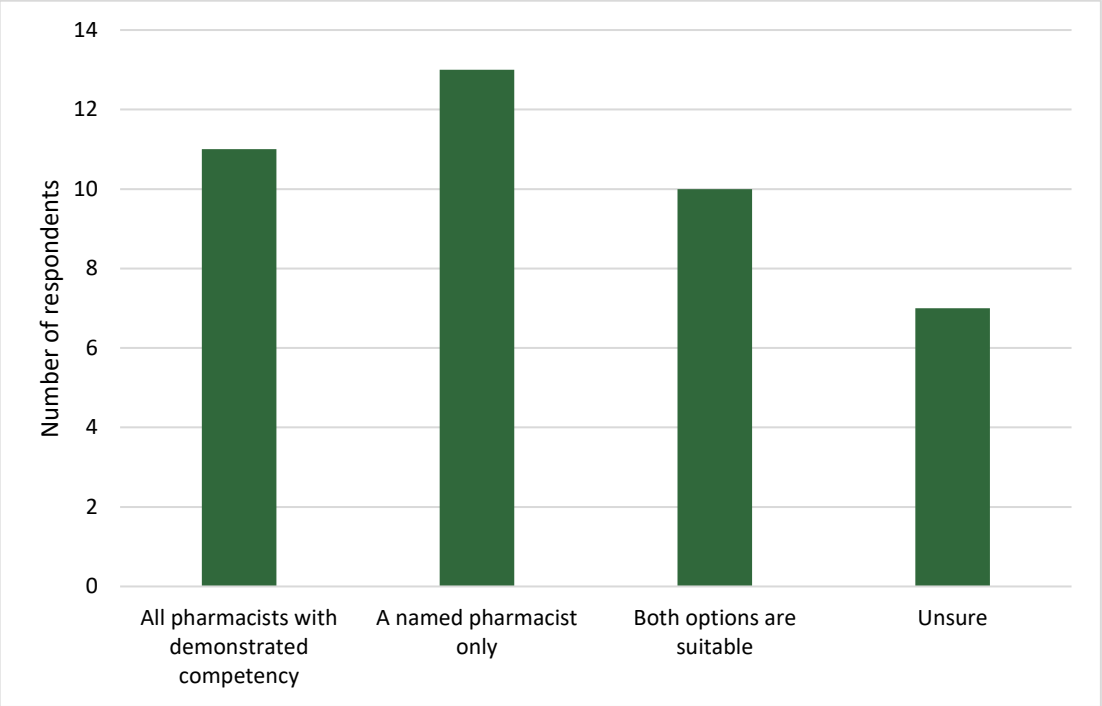


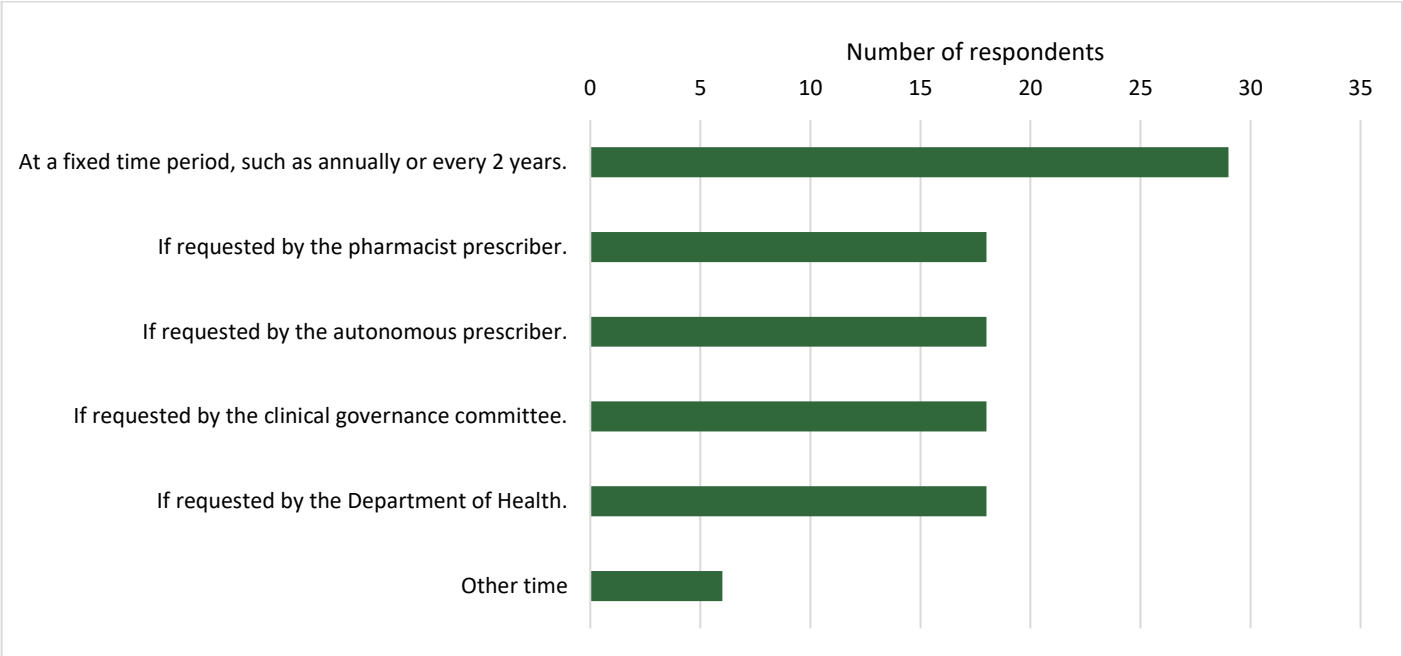
Figure 16: Review of prescribing agreements

Recommendation 12

Allow individual healthcare organisations/services to determine whether they will allow collaborative prescribing agreements to apply to all pharmacists with demonstrated competency and suitable scope of practice and/or only allow agreements to apply to a named pharmacist or pharmacists.

The last question in the section about collaborative prescribing agreements for pharmacists was about when these agreements should be reviewed. Respondents could choose multiple options.

Figure 16: Review of prescribing agreements



Other options for review provided by respondents included:

- Allowing anyone in the clinical team to request a review.
- Requiring reviews at a shorter fixed time period initially.
- Regular review but annually is too frequent.
- Decrease review interval if issues arise.
- Support for using reviews as a mechanism to strengthen safeguards.

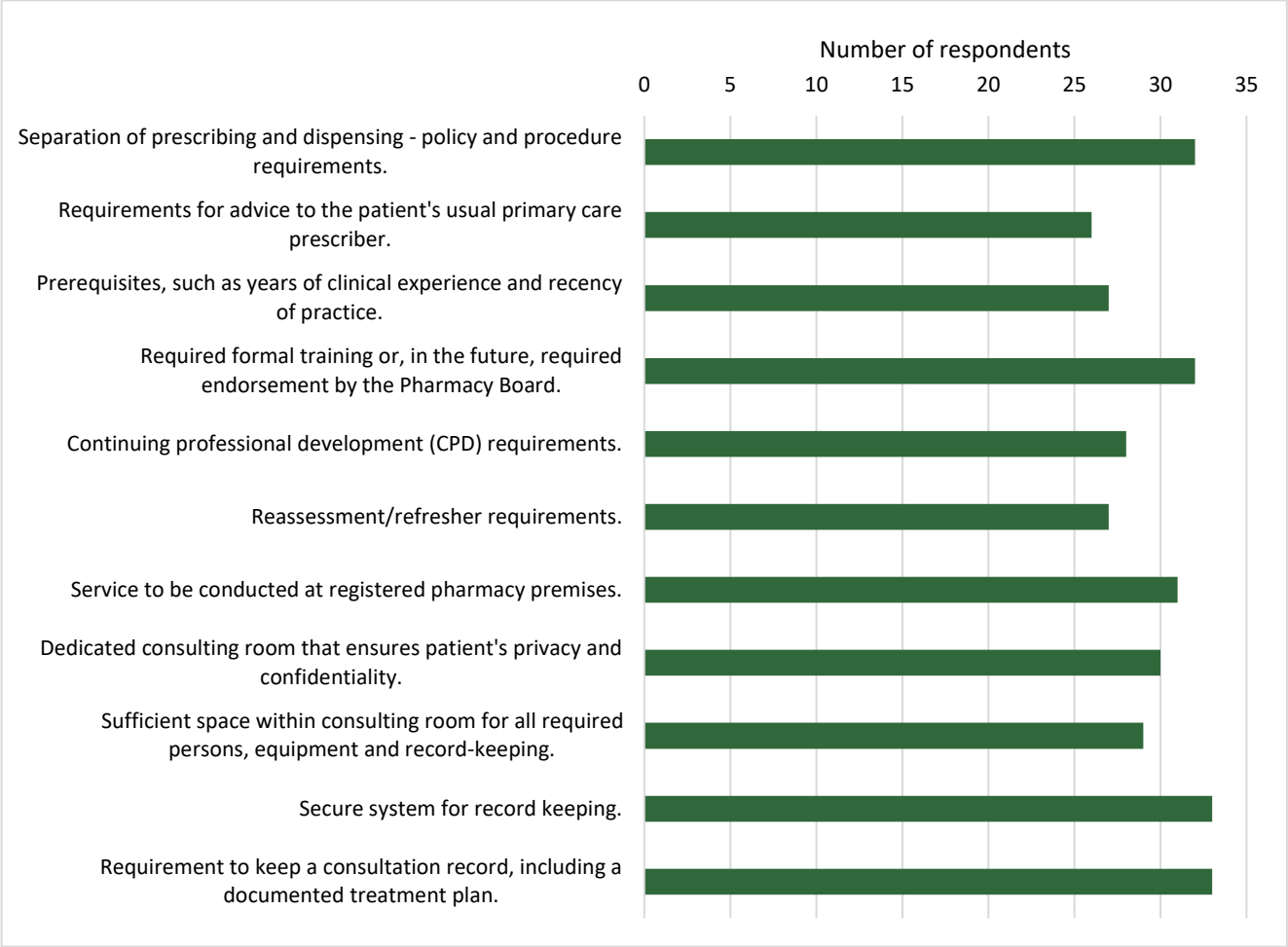
Recommendation 13

- Include a requirement in the Prescribing Instrument that the employing/contracting healthcare organisation/service must have a formal review process for collaborative prescribing agreements.
- Include a condition in the Prescribing Instrument that the Department of Health can request a collaborative prescribing agreement be reviewed by the relevant clinical governance committee responsible for approving the agreements, with the outcome of the review to be provided to the Department.

Pharmacists: Prescribing instrument content for the Enhanced Access Community Pharmacist Pilot (EACPP)

The consultation questions asked respondents to choose from a list of specific requirements that could be included in a Prescribing Instrument, applicable to pharmacists prescribing within the EACPP. The requirements were listed under broad headings: governance, pre-requisites and training, resources and record-keeping. Thirty-four respondents answered the question and there was a high level of support for inclusion of all the suggested requirements.

Figure 17: Prescribing instrument content



Most of the proposed requirements will already be embedded within the EACPP. For example, communication with the patient's regular general practitioner or medical centre, provided the patient has consented to this, will be a standard part of caring for a patient under the EACPP. Similarly, patients who are issued with a prescription under the EACPP must be informed that they can take their prescription to any pharmacy for dispensing. Where the patient chooses to have their prescription dispensed at the pharmacy at which it was issued, recommended practice is for another pharmacist to dispense the prescription, provided this does not negatively impact the patient's access to care.

The EACPP will be a structured pilot with continuous monitoring from implementation, with evaluation of safety, effectiveness and outcomes for consumers.

Some aspects of the EACPP are already finalised including approved training courses for pharmacists and requirements for the premises in which the EACPP can be conducted. Clinical guidelines and protocols to guide pharmacists are currently under development, with oversight by a clinical reference group. Pharmacists participating in the EACPP will be required to practise within these guidelines and protocols, including adhering to clear inclusion and exclusion criteria and following criteria for referral and escalation to a general practitioner or emergency care facility.

Further information about the EACPP is available on the Department of Health's website at: https://www.health.wa.gov.au/Articles/A_E/Enhanced-Access-Community-Pharmacy-Pilot.

Respondents were invited to provide advice about other requirements that would be suitable for including in a Prescribing Instrument applicable to pharmacists prescribing as part of the EACPP. Suggestions included:

- Limiting which medications can be prescribed.
- Mandate use of a specific secure record keeping system, to provide a consistent format for documenting consultations.
- Require pharmacists participating in the EACPP to complete CPD hours specific to prescribing.
- Minimum staffing requirements within community pharmacies.
- Financial separation between the prescribing pharmacist and the dispensing pharmacy.

Requirements for specific training (including relevant CPD and refreshers), clinical experience and recency of practice could initially be included in a Prescribing Instrument for pharmacists. However, these aspects are related to whether a pharmacist would be considered qualified to prescribe. Once the Pharmacy Board of Australia's proposed endorsement for scheduled medicines for pharmacists is in place, such requirements would be more appropriately regulated by the Board.

Recommendation 14

- Require pharmacists prescribing as part of the EACPP to comply with published training, premises, guidelines and protocols and record-keeping requirements of this particular primary care service, through a Prescribing Instrument issued by the Chief Executive Officer of the Department of Health and published on the Department of Health's website.
- Limit any additional requirements in the Prescribing Instrument to those essential to ensuring protection of public health.

Withdrawal of prescribing agreements

In the event that a prescribing agreement is considered to pose a significant risk to the health, safety or welfare of a person or the public, a regulatory option is to include a provision to allow the Chief Executive Officer (CEO) of the Department of Health to direct the agreement be withdrawn. Such a provision would be applicable to a prescribing agreement between any class of health practitioner, including prescribing agreements involving both pharmacists and designated registered nurse prescribers.

A similar withdrawal provision already exists within the Regulations, for Structured Administration and Supply Arrangements (SASAs) issued by health organisations and issued by individual medical practitioners.

There are existing provisions within the Act, which allow the CEO of the Department to restrict the professional authority an authorised health professional, with respect to their handling of scheduled medicines. Where there were significant concerns about the safety of a prescribing agreement, a health practitioner could have a condition placed on their professional authority that prevented them from entering into prescribing agreements. The Act includes clauses that provide the health professional with an opportunity to be heard on the matter, and a right of review via the State Administrative Tribunal. The Act also allows the

Department to advise the health practitioner's registration board if action is taken to restrict, suspend or cancel their professional authority.

The consultation questions sought an indication of the level of support for each option.

Figure 18: Support for specific provision for CEO of Health to direct withdrawal of prescribing agreement

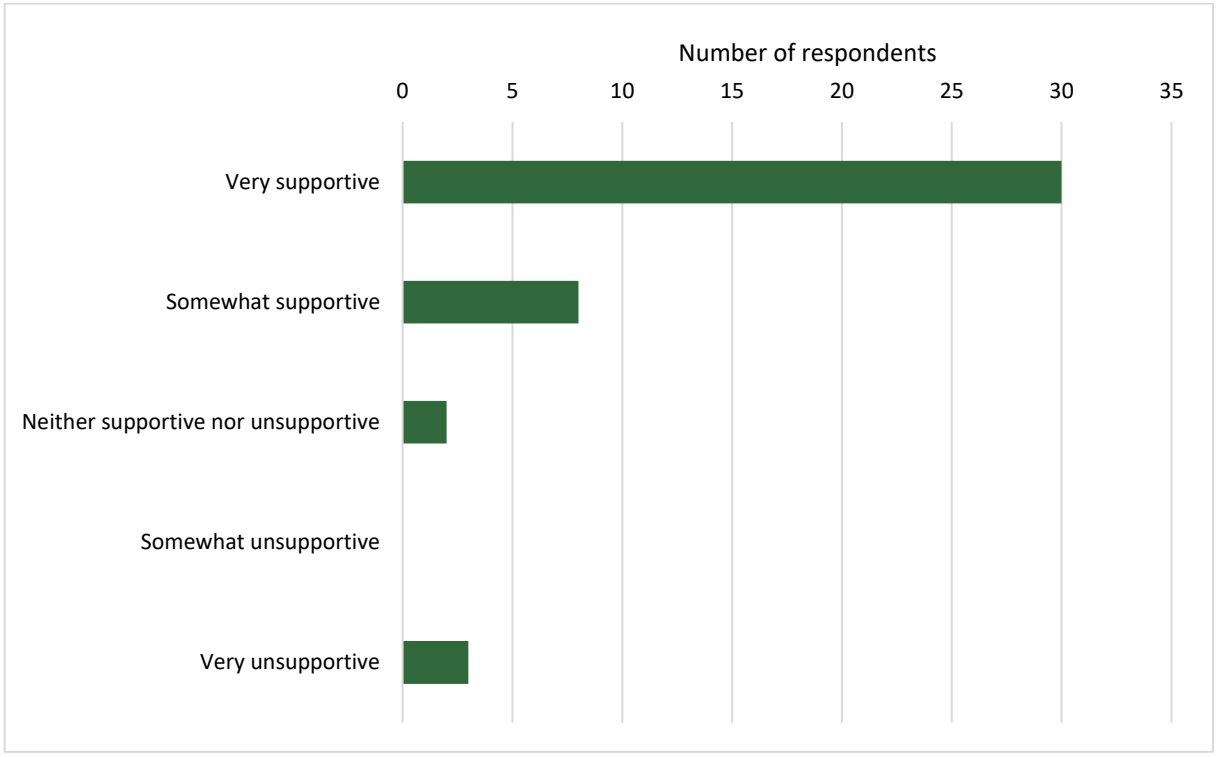
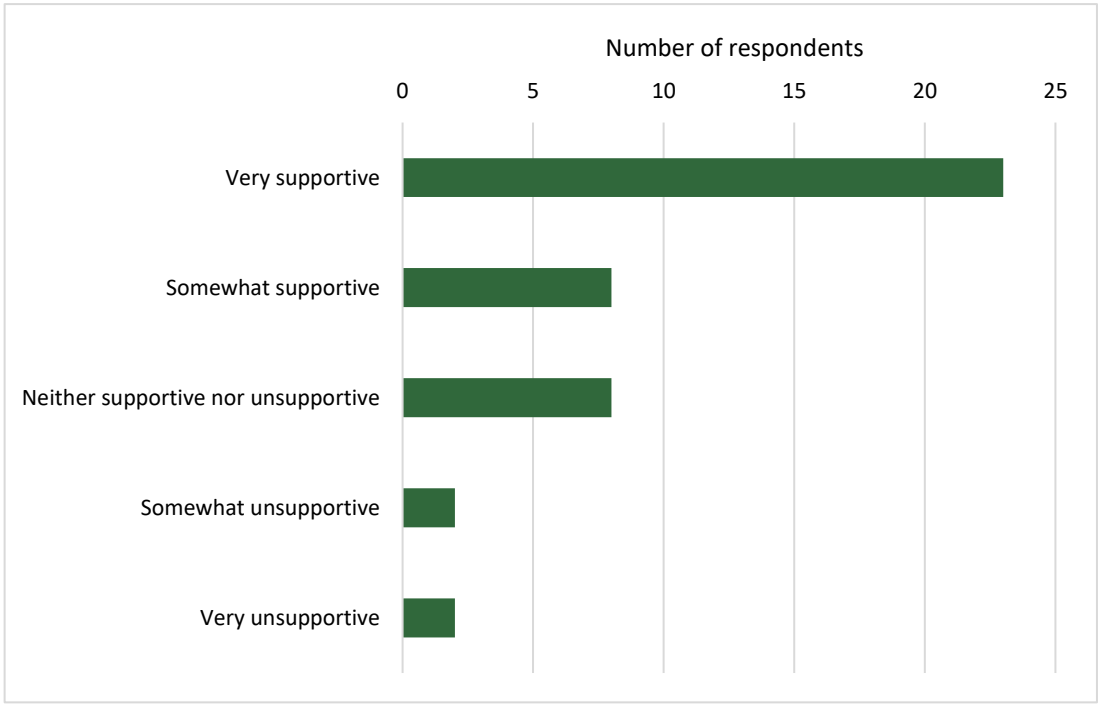


Figure 19: Support for using currently available provisions within the Act



Of those who were very supportive of having specific regulations about withdrawal of prescribing agreements, 19 out of 30 (63.3%) also provided strong support for using the existing provisions of the Act.

Recommendation 15

- Include specific provisions in the Medicines and Poisons Regulations 2016 to allow the Chief Executive Officer of the Department of Health to direct that prescribing agreement between one or more health practitioners and one or more autonomous prescribers be withdrawn.
- Initially such a provision would only apply to prescribing agreements applicable to designated registered nurse prescribers and pharmacists. However, as other health practitioner classes may be involved in collaborative prescribing agreements in the future, it is preferable that such a provision apply to any collaborative prescribing agreement.

Next steps

The usual processes[16] for the drafting and enactment of subsidiary legislation, such as regulations, will be followed. The first step is to obtain approval from the Minister for Health to the Recommendations in this report.

Further focused consultation, with key stakeholder groups, is recommended as part of developing the proposed Prescribing Instrument.

[16] Available at: https://www.legislation.wa.gov.au/legislation/statutes.nsf/RedirectURL?OpenAgent&query=gettinggovernmentlegislationdraftedandenacted.pdf

Appendix 1 List of respondents

Seventeen respondents indicated their identity could be published. The other 34 respondents wished to remain anonymous.

Responses from organisations	
1	Australian Primary Health Care Nurses Association
2	Australasian College of Dermatologists
3	The Royal Australian College of General Practitioners – Western Australia
4	Alcohol and other Drug Consumer & Community Coalition
5	Pharmaceutical Society of Australia
6	Pharmaceutical Defence Limits (PDL)
7	MDA National
8	Advanced Pharmacy Australia (AdPhA) and Western Australia's Chief Pharmacists Forum (WACPF)
9	Nursing and Midwifery Board of Australia
Responses from individuals	
10	Wendy Pearson
11	Katie Janz
12	Jodi Williams
13	Casmir Emengini
14	Julia Rawlinson
15	Sally Coppock
16	James Tidder
17	Damien Zilm

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