Collegian 30 (2023) 620–626

Contents lists available at ScienceDirect

Collegian

journal homepage: www.elsevier.com/locate/colegn

A survey of nurse practitioner's views on registered nurse prescribing in Australia — Conflicted perspectives

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ARTICLE INFO

Article history:
Received 24 March 2023
Received in revised form 12 April 2023
Accepted 23 April 2023

Keywords:
Nurse
Nurse practitioner
Prescribing
Scope of practice
Professional education
Access to care
Medication management

ABSTRACT

Background: The Nursing and Midwifery Board of Australia has proposed a standard of practice that enables registered nurses (RNs) to prescribe under a partnership model. This requires extensive input and support from authorised prescribers including nurse practitioners. Understanding nurse practitioners' views and preparedness to support partnership nurse prescribing is imperative to its successful adoption.
Aim: To report Australian nurse practitioners' views on the RN-prescribing standard.
Methods: This cross-sectional study surveyed a convenience sample of nurse practitioners using multiple-choice, Likert Scale and open-text responses. Quantitative data were analysed using descriptive statistics; short answer responses were explored thematically.
Findings: The majority of the 229 participants (n = 183, 76.2%) agreed that prescribing would optimise RN knowledge, skills, and capability. Mentorship was the highest-rated enabling factor (n = 205, 89.5%). Three themes were identified: the lived experience of nurse practitioners, perceived impact on nurse practitioner roles, and patient safety.
Discussion: Participant views were conflicted. While the potential advantages for patients, RNs, and the healthcare system were acknowledged, there was equal concern for the implementation of nurse prescribing, role ambiguity, and erosion and patient safety. Nurse practitioners' support for RN prescribing will be an important component of implementation.
Conclusion: RN prescribing is an opportunity to potentially improve consumer access to medicines and enhance healthcare system efficiency. It is also an opportunity for the nursing profession to contribute to improved systems of care while embedding succession planning for advanced practice nursing roles.
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https://doi.org/10.1016/j.colegn.2023.04.005
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Summary of relevance

Problem or Issue

The Nursing and Midwifery Board of Australia has proposed a standard of practice that will enable registered nurse prescribing under a partnership model. Implementing this model is dependent upon authorised prescribers, including nurse practitioners partnering with registered nurses.

What is already known

Registered nurses are prepared to undertake further educational programs and expand practice to included prescribing under supervision. Support and mentorship of authorised prescribers are essential to workforce preparation for this role.

What this paper adds

This paper reports nurse practitioner views of the proposed prescribing practice standard and the implementation of registered nurse prescribing in partnership.

1. Introduction

Health workforces globally are expanding non-medical health professional roles to include prescribing at various levels to improve access to medicines and health outcomes (Courtenay, Deslandes, Harries-Huntley, Hodson, & Morris, 2018; Ladd & Schober, 2018). The International Council of Nursing has encouraged expansion of the nursing scope of practice to include prescribing as one method to address unmet healthcare need (Stewart et al., 2021). The Nursing and Midwifery Board of Australia (NMBA, 2018) has proposed the introduction of a standard of practice that would enable registered nurses (RNs) to prescribe in partnership. This standard aligns with Model 2 of the Health Professionals Prescribing Pathway (HWA, 2013) and requires authorised prescribers to supervise RN prescribing (NMBA, 2018). In Australia, medical practitioners, nurse practitioners, and endorsed midwives are authorised to independently prescribe medicines. There are preparatory efforts in planning for RNs to prescribe within a partnership model. Successful adoption of prescribing in such a partnership model is dependent upon authorised prescribers' preparedness and capability in two ways. First, to support the development and provision of an educational course to prepare RNs for prescribing and second to practice in partnership with RNs under a collaborative prescribing model.

Nurse prescribing began in the United States of America when the first nurse practitioner course was developed and delivered at the University of Rochester and nurse practitioners were granted prescribing rights (1969) (Haririan, Seresht, & Hassankhani, 2022). Non-medical prescribing was introduced in the United Kingdom (UK) in the early 1990s. A systematic review exploring the implementation of non-medical prescribing in the United Kingdom has reported concerns about a lack of understanding of the role of non-medical prescribers and trust in non-medical prescribers (Graham-Clarke, Rushton, Noblet, & Marriott, 2018). In Australia, nurse prescribing began in 2001 when nurse practitioners in several jurisdictions were granted prescriptive authority (Dunn, Cashin, Buckley, & Newman, 2010; Fong, Buckley, Cashin and Pont, 2017). Since 2012, Australian midwives who have successfully completed an NMBA-approved prescribing program are eligible for endorsement to prescribe scheduled medicines (NMBA, 2022b).

Non-medical prescribers in most countries are required to complete formal postgraduate study before undertaking the expanded role of prescribing (Raghunandan, Tordoff, & Smith, 2017). Evidence suggests that, where medical staff were involved in the training, developing and/or delivering the curriculum, mentoring and assessing participants' non-medical prescribers felt more supported to undertake the role (Graham-Clarke et al., 2018). In response to varied curriculum and modes of education delivery, The Royal Pharmaceutical Society's Competency Framework for All Prescribers (RPS, 2016) has been adopted by the Nursing and Midwifery Council as a standard guide to proficiency levels of prescribing courses for all nurses and midwives in the United Kingdom (NMC, 2018). In Australia, a prescriber assessment toolkit that recommends methods of assessment aligned to the National Prescribing Competencies was developed, the Assessment of Prescribing in Health (Cardiff et al., 2017). Educational preparation and inclusivity of all stakeholders in the process is key to the successful implementation of nurse prescribing more broadly in Australia (Fox et al., 2022b).

A cross-sectional survey was recently undertaken to explore Australian RN views on expanding practice to include prescribing (Fox et al., 2022a). This study reported that of the 4424 nurses surveyed, 82% (n = 3645) expressed their willingness to undertake further study and expand their scope of practice to incorporate prescribing (Fox et al., 2022a). Of those who indicated they would undertake education in prescribing, over 91% (n = 3992) reported mentors as a strong enabler of nurse prescribing with multidisciplinary colleague involvement in the development of nurse prescribing and support in the clinical setting imperative to the success of RN prescribing (Fox et al., 2022a).

The implementation of RN prescribing in partnership has implications for authorised prescribers such as medical and nurse practitioners. Nurse practitioners in Australia complete a master-level qualification through an NMBA-accredited course, are endorsed to practice in the title-protected role of a nurse practitioner and have authority to prescribe medicines (NMBA, 2021). These advanced practice nurses have firsthand experience of expanding their scope of practice to include authorised prescribing, and how to practice in collaborative partnerships, and are well placed to advocate for, and support RN prescribing in Australia.

Examining nurse practitioners' views on the education and training needs to prepare RNs for prescribing, and their views on supervising and mentoring RN prescribing, is important to appreciate the potential feasibility and sustainability of RN prescribing (Fox et al., 2021). The data reported here on nurse practitioners' views on RN prescribing were collected as part of a larger cross-sectional survey (Fox et al., 2022a). This study aimed to report Australian nurse practitioners' views on RN prescribing and implementation of this expanded practice model.

2. Methods

2.1. Design

This cross-sectional study used a questionnaire distributed online via an email invitation.

2.2. Participants

Convenience sampling of Australian nurse practitioners was sought via email distribution of the survey link through professional and industrial organisations, including the Australian College of Nurse Practitioners, the peak body for nurse practitioners, and the Australian College of Nursing, the peak body for RNs. A complete list of organisations has been provided in Supplementary information (S1). This study is reported using the Strengthening the Reporting of Observational Studies in Epidemiology guidelines for cross-sectional studies (Von Elm et al., 2007), the checklist is available in Supplementary information (S2).

2.3. Survey instrument

The questionnaire consists of 32 items and included a range of demographic and experience questions. Participants were asked

their views on anticipated outcomes of RN prescribing and factors that may enable implementation of the proposed standard of practice. The survey included multiple-choice, Likert-Scale response questions and three questions that allowed open-text responses (Fox et al., 2022a). Content validity was tested by a panel of 10 members using the Content Validity Index for Relevance and Clarity (Lynn, 1986) and a pilot survey was conducted with a group of 10 nurses, which resulted in minor changes for clarity (Fox et al., 2022a).

2.4. Ethical approval

The Queensland University of Technology, Human Research Ethics Committee (#2000000418), approved this study.

2.5. Data analysis

Demographic data were analysed using descriptive statistics software via the IBM SPSS Statistics (version 27). Participant responses to Likert-Scale questions about perceived outcomes and enabling factors were condensed from strongly agree, agree, neutral, disagree and strongly disagree to agree and neutral and disagree in order to improve interpretation of the findings.

Short answer responses were analysed using thematic analysis methods independently by two authors (CT and AF) with experience in qualitative methods for health research. Thematic analysis techniques as described by Braun and Clarke (2006), six stages of coding and categorising were used to analytically examine written text to determine trends and patterns (Krippendorff, 2018). Identification of themes was achieved by reviewing the frequency and commonality of responses. Following their independent analysis, the two researchers (CT, AF) met on three occasions, to review and discuss their interpretations of the data until consensus was achieved on the themes that best reflected the responses.

Table 1
Characteristics of the sample.

Age (n = 228)	**n (%)**
20–39	23 (10.0)
40–49	73 (31.9)
50–59	103 (45.0)
> 60	29 (12.7)
Aboriginal or Torres Strait Islander (n = 228)	
Yes	3 (1.3)
No	223 (97.8)
Prefer not to answer	2 (0.9)
State (n = 213)	
NSW	72 (33.8)
QLD	66 (31.0)
VIC	27 (12.7)
WA	21 (9.9)
SA	22 (10.3)
ACT	5 (2.3)
Country of qualification (n = 229)	
Australia	183 (79.9)
Overseas	46 (20.1)
Highest qualification (n = 229)	
Post-grad cert or diploma	5 (2.1)
Master's degree	216 (94.3)
Doctoral degree	8 (3.5)
Years of experience as a nurse practitioner (n = 229)	
< 5 years	73 (31.9)
5 to < 10 years	69 (30.1)
10 to < 15 years	70 (30.6)
15 or more years	17 (7.4)
Employment capacity (n = 229)	
Full time	147 (64.2)
Part time	63 (27.5)
Casual	6 (2.6)
Not employed	13 (5.7)
Workplace setting (n = 229)	
Public hospital	139 (60.7)
Private hospital	3 (1.3)
Community or primary health service	51 (22.3)
Residential aged care or retirement village	5 (2.2)
Other[a]	31 (13.5)
Patient group (n = 218)	
Adults	155 (69.5)
Across the lifespan	39 (17.5)
Paediatrics	21 (9.4)
Neonatal	3 (1.3)

[a] Other may refer to nurse practitioners working in private practice.

3. Results

A total of 229 nurse practitioners completed the online survey. This is approximately 9.4% of the Australian nurse practitioner population (Nursing and Midwifery Board of Australia, 2022a). Respondents were mostly (n = 132, 57.7%) aged 50 years or over, residing in New South Wales (n = 72, 33.8%), and were working full time (n = 147, 64.2%) in public hospital settings (n = 139, 60.7%). Full participant characteristics are presented in Table 1.

3.1. Outcomes and enablers of nurse prescribing

Participant responses to the expected outcomes and the factors that enable RN prescribing are presented in Table 2. The majority (n = 183, 76.2%) of participants agreed that RN prescribing would improve the use of nurses' knowledge, skills and capability, increase access to nurse-led models of care (n = 172, 75.1%), and improve healthcare system capacity (n = 153, 68%). The highest-rated enabling factor for introducing RN prescribing was the availability of appropriate mentors (n = 205, 89.5%).

3.2. Workforce preparation expectations

The responses to workforce preparation expectations are presented in Table 3. The majority (n = 116, 55.8%) of nurse practitioners reported that a minimum of 5 years of prior clinical nursing experience would be required to undertake a nurse-prescribing course, while 49 (23.6%) thought 10 or more years and 38 (18.3%) thought that a minimum of 2-year full-time-equivalent experience was sufficient. The majority (n = 142, 62%) of respondents thought that universities or, universities in collaboration with health services (n = 118, 51.5%), were the most appropriate organisation to develop and deliver an educational program for RN prescribing. Three-quarters of nurse practitioners (n = 172, 75.1%) reported that blended (online and face-to-face) learning was the most appropriate format for the program, followed by workplace-integrated learning (n = 147, 64.2%) and simulation (n = 117, 51.1%). Almost half of the participants (n = 100, 47.4%) reported that the educational program should be developed to a master's degree level, followed by graduate diploma (n = 54, 25.6%) and graduate certificate (n = 46, 21.8%). Most (n = 110, 52.1%) reported that RN prescribers should receive an allowance if prescribing is required to fulfill their role.

3.3. Nurse practitioner views on nurse prescribing

Analysis of participant's short answer responses identified three themes: lived experience of nurse practitioners, concern about the impact on the nurse practitioner role, and fear of patient harm, as discussed below.

3.3.1. The lived experience of nurse practitioners: barriers to extending the scope of practice

Participants reflected on the organisational and legislative challenges they have faced trying to practice to their full scope. Although there is support for the introduction of nurse prescribing, nurse practitioner participants highlighted that the same challenges they

Table 2
Participants' agreement with expected outcomes and enabling factors for RN prescribing.

Implementing RN prescribing will	Disagree	Neutral	Agree
1. Improve use of RN knowledge, skills, and capability	23 (10.1)	31 (13.5)	173 (76.2)
2. Increase access to nurse-led models of care	24 (10.5)	33 (14.4)	172 (75.1)
3. Improve capacity of the Australian healthcare system due to a more flexible workforce	29 (12.9)	43 (19.1)	153 (68.0)
4. Improve patient healthcare experience	31 (13.7)	42 (18.5)	154 (67.5)
5. Improve patient education regarding medicines	31 (13.7)	49 (21.8)	145 (64.5)
6. Improve patient access to prescription medicines	29 (12.7)	41 (18.1)	157 (69.1)
7. Improve healthcare delivery	38 (16.6)	44 (19.2)	146 (63.7)
8. Improve retention of clinicians within the nursing profession	38 (16.7)	58 (25.4)	132 (57.9)
9. Reduce costs to the Australian healthcare system	41 (18.1)	63 (27.5)	123 (54.2)
10. Reduce healthcare costs to the patient	47 (20.7)	69 (30.4)	111 (48.9)
11. Reduce safety risks for patients	65 (28.6)	71 (31.3)	91 (40.1)
Factors enabling RN prescribing are			
1. Availability of appropriate mentors and/or supervisors to facilitate role, skill, and knowledge development	12 (5.3)	12 (5.2)	205 (89.5)
2. Supportive legislation, regulation, and relevant health policy	12 (5.3)	11 (4.9)	203 (89.8)
3. Support from medical colleagues	18 (7.8)	14 (6.1)	196 (85.9)
4. Support from pharmacy colleagues	13 (5.7)	15 (6.6)	199 (87.7)
5. Models of nursing care that optimise use of nurse prescribing	10 (4.4)	15 (6.6)	201 (88.9)
6. Organisational commitment for implementation	11 (4.8)	14 (6.1)	204 (89.1)
7. Support from colleagues in the nursing profession	9 (4.0)	17 (7.5)	202 (88.6)
8. Acknowledgement of the impact on workload of RNs	19 (8.3)	23 (10.1)	186 (81.6)
9. Acceptance of nurse prescribing by patients/clients	12 (5.2)	32 (14.1)	183 (80.7)
10. Remuneration to acknowledge prescribing practice	26 (11.5)	36 (15.9)	164 (72.5)
11. Health services receive reimbursement for RN-prescribing activities	22 (9.6)	43 (18.8)	164 (71.6)
12. Unrestricted prescribing based on a clear scope of practice	60 (26.7)	45 (20.0)	120 (53.4)

RN: registered nurse.

Table 3
Participant responses to questions about RN education and preparation for prescribing.

How much clinical nursing experience should be required before commencing a prescribing program?	**N (%)**
Less than one-year full-time equivalent	-
1 to <2 years full-time equivalent	5 (2.4)
2 to <5 years full-time equivalent	38 (18.3)
5 to <10 years full-time equivalent	116 (55.8)
10 or more years full-time equivalent	49 (23.6)
Which organisations are appropriate to develop and deliver the educational program?	
Universities	142 (62.0)
Health services in conjunction with universities	118 (51.5)
Individual health services (i.e., hospitals or health centres)	31 (13.5)
Health services in conjunction with TAFE institutions	11 (4.8)
TAFE institutions	5 (2.2)
What format is the most appropriate for the educational program?	
Blended learning (combination of online and contact learning)	172 (75.1)
Workplace-integrated learning	147 (64.2)
Simulation and/or role play	117 (51.1)
Modules/workbooks (online)	111 (48.5)
Face-to-face lecture/tutorial	108 (47.2)
Modules/workbooks (hard copy)	65 (28.4)
Lecture/tutorial (online)	64 (27.9)
What level of qualification should be delivered for RN prescribing?	
None	1 (0.5)
Certificate of attainment from a tertiary institution	10 (4.7)
Graduate certificate	46 (21.8)
Graduate diploma	54 (25.6)
Master's degree	100 (47.4)
Should RNs receive an allowance for prescribing?	
Nurse prescribers should receive qualification allowance	59 (28.0)
Nurse prescribers should receive qualification allowance if it is required to fulfil the RN's role	110 (52.1)
Nurse prescribers should **not** receive qualification allowance	27 (12.8)
Unsure	15 (7.1)

have experienced in progressing their roles may also be challenges to the implementation of nurse prescribing.

"[I] fully support this enhancement but feel that we are adding to an already flawed system where nurse practitioners have not been recognised or fully supported to achieve their full potential within the existing health system".

A challenge identified was the outside influences that impacted nurse practitioners' ability to work to their full scope of practice that may also pose challenges for RNs prescribing in partnership. For nurse practitioners, this has been an ongoing challenge and one that appears dominated by legislation written with a medical practitioner focus.

"Nurse practitioners are already legislated to be able to prescribe but due to Government obstacles; ……nurse practitioners are not able to work to their full scope of practice. This illustrates the problems are not to do with who the prescriber, but the medical model the Australian legislators refuse to move away from".

Participants suggested that in order for RN prescribing to be successful, support would be required from other healthcare professionals, particularly medical colleagues, amongst whom there have been varied perspectives on nurse practitioner scope of practice. *"I think the medical profession will need to be on board for this to progress, look at how restrictive their views have been on Nurse Practitioner practice, without Medical Association support, this will never happen".*

3.3.2. Concern about the impact on the nurse practitioner role: role erosion and confusion

The second theme identified was a concern that an increased scope of practice for RNs to prescribe may lead to erosion of the nurse practitioner role. Participants reported that if RNs have increased scope, this may reduce nurse practitioners' credibility and would risk diluting the nurse practitioner role and the endorsed title.

"My concern is that as nurse practitioners are "endorsed" the nurse prescribing will be an endorsement as it is in Midwifery - this however somewhat reduces the extensive training and internship etc required to become a nurse practitioner".

Further, some participants perceived that the potential overlap of roles and responsibilities might impact the value of nurse practitioner roles within the interdisciplinary team:

"I believe that the role of nurse practitioners would be significantly devalued if this model was to go ahead and will undo the decades of progress in community and interdisciplinary acceptance of the role of nurse practitioners".

Finally, nurse practitioners were concerned that RN prescribing may cause confusion for health practitioners, patients, and the public: *"why is another level needed [it] will just confuse other health care professionals and the public".*

3.3.3. Fear of patient harm: education, skills and system barriers

The final theme that resonated through the nurse practitioner participants' responses was a multifactorial concern for safety of the public. First, some participants were concerned about RNs' knowledge and skills in relation to the educational preparedness of RN prescribers:

"Whilst I feel this is a positive move, I do not feel that the existing knowledge, skills and capability of RN is acceptable without further education and strict protocols or guidelines to ensure safe use of medicines".

Another concern was that RN prescribers would not necessarily have the advanced assessment skills that nurse practitioners possess to support safe practice:

"I am concerned that many nurses lack an understanding of the importance of a proper assessment, and how the body systems, medications, chronic illnesses, past history and diagnosis all interact when choosing prescription medicines".

Further to concerns about knowledge and skills, some participants perceived that the addition of another layer of prescriber may increase drug errors: *"We already have a situation where patients have multiple prescribers. Bringing more prescribers in to the mix increases chances of adverse drug interactions and errors".* This was linked to diminished continuity of patient care:

"I think the RN role in the hospital setting can be transient involvement which may not allow for adequate patient follow up post prescription, which would be a safety issue".

Finally, one participant highlighted that adding another task for already time-poor nurses may lead to adverse outcomes for patients.

"Nurses in acute care are generally time poor and have many conflicting priorities and moving prescribing onto nurses in this context may not lead to improvements in health outcomes as it is just role shifting."

4. Discussion

Successful implementation of RN prescribing in Australia will require collaboration, support, and building of trust between all healthcare practitioners (Fox et al., 2021; Bowskill, Timmons, & James, 2013). Nurse practitioners, as authorised prescribers and advanced practice nurses providing direct and holistic patient care, are uniquely positioned to facilitate the implementation of supervised RN prescribing. The findings suggest that the majority of participants were positive about the potential benefits of RN prescribing. Overall, participants perceived that the extension of RN scope of practice to prescribing will enhance RN knowledge, skills, and capability, while improving consumer access to medicines and increasing service capacity within health organisations if it is well supported. This was consistent with previous findings cited in the international literature (Currie, 2018; Kroezen et al., 2014).

Nurse practitioner views of this expanded scope of practice for RNs were conflicted. Respondents expressed concerns regarding the systems-level impact of RN prescribing from the perspective of patient safety, organisation/legislative barriers, and education and the impact that RN prescribing might have on NP roles. Fears surrounding the safety of nurse prescribing are likely unfounded. The past two decades of nurse prescribing in the United Kingdom have shown nurse prescribing to be a safe and innovative service (Courtenay, 2018). A review examining the clinical effectiveness of non-medical prescribing reported it to be safe and provide good clinical outcomes (Noblet, Marriott, Graham-Clarke, Shirley, & Rushton, 2018). A review conducted by Weeks, George, Maclure and Stewart (2016) reported non-medical prescribers to be as effective as medical prescribers in a range of settings, for example, the management of patient's systolic blood pressure, glycated haemoglobin, low-density lipoprotein, medication adherence, patient satisfaction, and health quality of life.

Concerns raised about non-medical prescribing suggest role confusion and interdisciplinary conflict are problematic (Courtenay et al., 2018). Pritchard (2018) reported that in England when authority to prescribe was unclear, relationships between medical practitioners and nurses became strained, and an adjustment of care processes was required. Role clarification and developing trust between nurses and authorised prescribers is essential to the success of the prescribing partnership, but if professional boundaries are unaddressed, it can cause division and prevent uptake of nurse prescribing (Courtenay et al., 2018; Pritchard, 2018).

Non-medical prescribing in the United Kingdom contributes to improved health outcomes and equity for consumers and increased job satisfaction for nurse prescribers (Courtenay, 2018; Graham-Clarke, Rushton, Noblet, & Marriott, 2019). As noted by many of the nurse practitioner participants, legislative, service, and organisational barriers previously experienced by nurse practitioners are likely to impact national implementation of RN prescribing too. The role of NPs has required renegotiation of historical hierarchical boundaries between nurses and medical practitioners (Schadewaldt et al., 2016). For example, in Australia, authorised prescribers' ability to prescribe medicines is limited by the governing legislation within the jurisdiction and/or state they are working (Boase et al., 2017). As a consequence, nurse practitioner prescribing in some states such as Victoria is limited by a requirement for formularies or protocols. It may also be limited at the local level by health service governance. To avoid limiting the potential of nurse prescribing, it will be important to ensure that jurisdictional legislation supports opportunities to optimise the scope of practice.

Participants perceived that extending the scope of practice of RNs to include prescribing may erode nurse practitioner roles, some of which have struggled to be integrated and accepted within some areas of the Australian healthcare system. The challenge of implementing nurse practitioner roles resonates with the findings of a New Zealand survey of 36 experienced nurse practitioners working in primary health care who highlighted role and scope confusion as a disadvantage of RN prescribing (Currie, 2018). Nurse practitioner roles were implemented in Australia with marginal strategic support at government or organisation levels resulting in underutilisation of the nurse practitioner model of care, which, in some circumstances, has restricted the scope and capacity of this model (Fox, Gardner, & Osborne, 2018). RN prescribing is less likely to cause nurse practitioner role erosion if it is driven by health services in response to service need and in collaboration with nurse practitioner and medical officers, with the intent to enhance patient experience and service capacity. While prescribing is an authority that differentiates the nurse practitioner scope of practice from other nursing roles, it is

only one element in the nurse practitioner domain. There are other elements such as advanced health assessment, diagnosis, and clinical management of consumers within a specialty area (Nursing and Midwifery Board of Australia, 2021). Collectively, these elements enable nurse practitioners the authority to provide full episodes of patient care.

RNs in Australia are well placed to undertake nurse prescribing providing it is introduced with supportive education and legislation. Effective implementation of RN prescribing is dependent on collaboration between, and endorsement of key stakeholders such as nurse practitioners (Currie, 2018). Mentoring and coaching at the point of care will be key to successful implementation of RN prescribing (Fox et al., 2022b). Clinical leadership and education are intrinsic to the Australian Nurse Practitioner Standards for Practice (Nursing and Midwifery Board of Australia, 2021) and a recent study of nurse practitioner work patterns suggests that development of a sustainable nurse practitioner workforce is linked to true integration of nurse practitioners into the workforce (Lowe, Tori, Jennings, Schiftan, & Driscoll, 2021). Formally engaging nurse practitioners in the facilitation and education of RNs to prescribe would provide an opportunity for nurse practitioners to support professional development pathways and succession planning.

4.1. Limitations

This research was a cross-sectional survey that received responses from nurse practitioners across a large geographic area and across multiple nursing specialties. It is acknowledged that a response bias may exist in survey data collection methods. The questionnaire provided limited response options and therefore the results may not reflect all participants' views of RN prescribing or contextual variances. Further research exploring the preparedness of nurse practitioners and other authorised prescribers to support RN prescribing is recommended.

5. Conclusion

The introduction of RN prescribing under a partnership model has the potential to increase access to medicines and facilitate innovative models of care to improve healthcare access for Australian communities. Previous research findings suggest that RNs are prepared to undertake this expanded practice, and this study indicates that nurse practitioners acknowledge the advantages of RN prescribing. Future implementation efforts should acknowledge concerns of nurse practitioners and engage them in facilitating future success of nurse prescribing.

Author contributions

Amanda Fox: Conceptualisation, Project administration, Methodology, Acquisition of data, Formal analysis, Interpretation of data, Writing original draft, reviewing and editing of the manuscript. **Raymond Chan**: Conceptualisation, Methodology, Acquisition of data, Formal analysis, Interpretation of data, Reviewing and editing of the manuscript : **Fiona Crawford-Williams**: Methodology, Formal analysis, Interpretation of data, Writing original draft, reviewing and editing of the manuscript. **Suzanne Williams**: Interpretation of the data, writing, reviewing and editing of the manuscript. **Jane Currie**: Interpretation of the data, Reviewing the manuscript. **Carla Thamm**: Formal analysis, Interpretation of data, Writing original draft, reviewing and editing of the manuscript.

Funding

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Ethical statement

This study was approved by the Queensland University of Technology Human Research Ethics Committee (#2000000418).

This paper reports the original research of the authors and has not previously been published or under consideration elsewhere. The authors have all seen and approved the paper submission to the Collegian and abide by the copyright terms and conditions of Elsevier and the Australian College of Nursing.

Conflict of interest

The authors of this paper report no conflict of interest.

Acknowledgements

The research team would like to acknowledge the support of the Australian Nursing and Midwifery Federation in the states of QLD, NSW, SA and VIC who assisted with distribution of the survey link to members along with the Australian College of Nurse Practitioners, College of Emergency Nurses Australia and individual Hospital and Health Services who assisted with distribution of the survey link to registered nurses in their networks.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.colegn.2023.04.005.

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