Independent and Supplementary Prescribing

An Essential Guide

Edited by
Molly Courtenay • Matthew Griffiths
Foreword by June Crown CBE

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To

Tim, Tom and Kath. The last book . . . . . maybe
Donna, Hope and Oscar. The last book . . . . . definitely

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Foreword

The extension of the authority to prescribe has moved on apace since the publication of the Review of the Prescribing, Supply and Administration of Medicines in 1999. Now nurses and pharmacists, as well as doctors and dentists, can prescribe, and they will soon be joined by other health professionals. These rapid developments have set challenges for professional and regulatory bodies and for individual practitioners. However, all concerned have risen to these challenges with energy and enthusiasm. Training programmes are well developed, many nurses and pharmacists have completed training, and the benefits to patients are already being felt.

This book is timely and I would like to congratulate Molly Courtenay and Matt Griffiths on bringing together a group of distinguished contributors who have produced an authoritative and comprehensive account of all aspects of prescribing. I am sure that it will prove invaluable both as a practical guide to new prescribers and a continuing reference source.

I hope that this book will not be seen only as a book for the new prescribing professions. Its thorough examination of all aspects of the prescribing process and the implications of extended prescribing for multidisciplinary teams should also commend it to existing prescribers. It is a valuable text for every professional who is learning to prescribe or who wishes to improve their practice.

I have no doubt that *Independent* and *Supplementary Prescribing* will inform and support prescribers and that it will make an important contribution to improvements in both the quality and accessibility of patient care.

Dr June Crown CBE

Preface

The introduction of non-medical prescribing has meant that nurses and pharmacists have had to expand their practice and so acquire new knowledge and skills in a number of fields. This new knowledge has had to be applied to the many issues surrounding prescribing in the practice setting. There are currently few books available that provide these prescribers with information to help them in this role. As non-medical prescribing extends to include allied health professionals, the need for such information will increase. This book is aimed at those non-medical professions involved in prescribing medicines.

Chapter 1 provides a general overview of non-medical prescribing and describes the current education and training available for extended independent and supplementary prescribers. Chapters 2–5 examine non-medical prescribing within a multidisciplinary team context, the different models of consultation that might be used by prescribers and the legal and ethical aspects surrounding prescribing. The psychology and sociology of prescribing, applied pharmacology and monitoring skills are explored in Chapters 6–8. Chapters 9–12 deal with medicines concordance, evidence-based prescribing, prescribing within a public health context and the calculation skills required by prescribers. The concluding chapter describes how independent and supplementary prescribing can be used by non-medical prescribers. The treatment management of patients with dermatological conditions are used as an example. It is hoped that insights gained from this chapter will be applicable to other practice settings.

Each chapter is fully referenced and where appropriate readers are offered suggestions for further reading and other information sources. We hope that this book will make a positive contribution in a very important aspect of patient care.

Molly Courtenay
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2004

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Chapter 1

Non-medical prescribing: an overview

Molly Courtenay and Matt Griffiths

In 1986, recommendations were made for nurses to take on the role of prescribing. The Cumberlege Report Neighbourhood Nursing: A Focus for Care (Department of Health and Social Security (DHSS), 1986) examined the care given to clients in their homes by district nurses (DNs) and health visitors (HVs). It was identified that some very complicated procedures had arisen around prescribing in the community and that nurses were wasting their time requesting prescriptions from the general practitioner (GP) for such items as wound dressings and ointments. The report suggested that patient care could be improved and resources used more effectively if community nurses were able to prescribe as part of their everyday nursing practice, from a limited list of items and simple agents agreed by the DHSS.

Following the publication of this report, the recommendations for prescribing and its implications were examined. An advisory group was set up by the Department of Health (DoH) to examine nurse prescribing (*Crown Report*, DoH, 1989). Dr June Crown was the Chair of this group.

The following is taken from the Crown Report:

> *Nurses in the community take a central role in caring for patients in their homes. Nurse are not, however, able to write prescriptions for the products that are needed for patient care, even when the nurse is effectively taking professional responsibility for some aspects of the management of the patient. However experienced or highly skilled in their own areas of practice, nurses must ask a doctor to write a prescription. It is well known that in practice a doctor often rubber-stamps a prescribing decision taken by a nurse. This can lead to a lack of clarity about professional responsibilities, and is demeaning to both nurses and doctors. There is wide agreement that action is now needed to align prescribing powers with professional responsibility.*
>
> DoH (1989)

The report made a number of recommendations involving the categories of items that nurses might prescribe, together with the circumstances under which they might be prescribed. It was recommended that:

> *Suitably qualified nurses working in the community should be able, in clearly defined circumstances, to prescribe from a limited list of items and to adjust the timing and dosage of medicines within a set protocol.*
>
> DoH (1989)

The Crown Report identified several groups of patients that would benefit from nurse prescribing. These patients included: patients with a catheter or a stoma, patients suffering with post-operative wounds and homeless families not registered with a GP. The Report also suggested that a number of other benefits would occur as a result of nurses adopting the role of prescriber. As well as improved patient care, this included improved use of both nurses' and patients' time and improved communication between team members arising as a result of a clarification of professional responsibilities (DoH, 1989).

During 1992, the primary legislation permitting nurses to prescribe a limited range of drugs was passed *(Medicinal Products: Prescribing by Nurses Act 1992).* The necessary amendments were made to this Act in 1994 and a revised list of products available to the nurse prescriber was published in the Nurse Prescribers' Formulary (NPF) (NPF, 2003). In 1994, eight demonstration sites were set up in England for nurse prescribing. By the Spring of 2001, approximately 20,000 DNs and HVs were qualified independent prescribers and post-registration programmes for DNs and HVs included the necessary educational component qualifying nurses to prescribe.

The available research exploring independent nurse prescribing by DNs and HVs indicates that patients are as satisfied, and sometimes more satisfied with a nurse prescribing as they are with their GP. The quality of the relationship that the nurse has with the patient, the accessibility of the nurse and their approachability, the style of consultation and information provided, and the expertise of the nurse are attributes of nurse prescribing viewed positively by patients (Luker *et al.*, 1998). Nurse prescribing enables doctors and nurses to use their time more effectively and treatments are more conveniently provided (Brooks *et al.*, 2001). Time saving and convenience (with regard to not seeing a GP to supply a prescription) are benefits reported by nurses adopting the role of prescriber (Luker *et al.*, 1997). Furthermore, nurses are of the opinion that they provide the patient with better information about their treatment and have reported an increased sense of satisfaction, status and autonomy (Luker *et al.*, 1997; Rodden, 2001).

A further report by Crown, which reviewed the prescribing, supply and administration of medicines, was published in 1999 (DoH, 1999). The review recommended that prescribing authority should be extended to other groups of professionals with training and expertise in specialist areas. During 2001, support was given by the government for this extension (DoH, 2001). Funding was made available for other nurses, as well as those currently qualified to prescribe, to undergo the necessary training to enable them to prescribe from an extended formulary.

This formulary included:

- A number of specified Prescription-Only-Medicines (POMs), enabling nurses to prescribe for a number of conditions listed within four treatment areas, i.e. minor ailments, minor injuries, health promotion and palliative care.
- General Sales List (GSL) items, i.e. those that can be sold to the public without the supervision of a pharmacist, used to treat these conditions.
- Pharmacy (P) medicines, i.e. those products sold under the supervision of a pharmacist, used to treat these conditions.

During 2003, proposals by the Medicines and Healthcare Products Regulatory Agency (MHRA, 2003) to expand the Nurse Prescribers Extended Formulary (NPEF) were accepted and the NPEF was extended to include a number of additional conditions and medicines (NPF, 2003). The government also promised that the formulary would be further extended in 2004 to include medicines prescribable by nurses working in first contact and emergency care.

Further legislation was also passed by the Home Office in 2003, allowing nurses to prescribe a number of controlled drugs (CDs). These include:

1. Diazepam, lorazepam, midazolam (schedule 4 drugs) for use in palliative care.
2. Codeine phosphate, dihydrocodeine and co-phenotrope (schedule 5 drugs).

A number of other CDs, included in the proposals set out by the MHRA (2003), are expected to be added to the NPEF in 2004, following Home Office approval. These include pain relief in palliative care and diamorphine in coronary care.

EDUCATIONAL PREPARATION FOR EXTENDED PRESCRIBERS

An outline curriculum for the educational preparation for extended independent prescribing was produced by the English National Board (ENB) for Nursing and Midwifery in September 2001 (ENB, 2001). Following the closure of the ENB, the Nursing and Midwifery Council (NMC) have continued to apply the ENB's existing standards and guidance for the approval of higher education institutions (HEIs) with regards to registerable and recordable programmes (Letters; 8 November 2001; 21 March 2002).

The extended independent prescribing programme is 3–6 months in length and includes 25 taught days, additional self-directed study, plus 12 days learning in practice with a medical mentor. The areas of study included within the prescribing module (ENB, 2001) are those general concepts that underpin prescribing. Topics include:

- Consultation, decision-making and therapy including referral
- Influences on and psychology of prescribing
- Prescribing in a team context
- Clinical pharmacology including the effects of co-morbidity
- Evidenced-based practice and clinical governance in relation to nurse prescribing
- Legal, policy and ethical aspects
- Professional accountability and responsibility
- Prescribing in the public health context.

SUPPLEMENTARY PRESCRIBING

The introduction of a new form of prescribing for professions allied to medicine was suggested in 1999 (DoH, 1999). It was proposed that this new form of prescribing,

i.e. 'dependent' prescribing would take place after a diagnosis had been made by a doctor and a Clinical Management Plan (CMP) drawn up for the patient. The term 'dependent' prescribing, has since been superseded by 'supplementary prescribing'.

Supplementary prescribing is *a voluntary prescribing partnership between an independent prescriber (doctor) and a supplementary prescriber (SP) (nurse or pharmacist, to implement an agreed patient-specific CMP with the patient's agreement* (DoH, 2002). Patients with long-term medical conditions such as asthma, diabetes or coronary heart disease, or those with long-term health needs such as anti-coagulation therapy are most likely to benefit from this type of prescribing.

Unlike independent prescribing, there are no legal restrictions on the clinical conditions for which SPs are able to prescribe. Nurses adopting the role of SP will be able to prescribe:

- All GSL and P medicines, appliances and devices, foods and other borderline substances approved by the Advisory Committee on Borderline Substances.
- All POMs with the current exception of CDs – the Home Office are currently deliberating on a consultation to potentially instigate changes in the law to make this possible.
- 'Off-label' medicines (medicines for use outside their licensed indications), 'black triangle' drugs and drugs marked 'less suitable for prescribing' in the British National Formulary (BNF).
- Unlicensed drugs may only be prescribed if they are part of a clinical trial with a clinical trial certificate or exemption (this may change following proposals set out by the MHRA (2004) enabling SP to prescribe unlicensed medicines).

Training for supplementary prescribing was introduced in 2003 for nurses and pharmacists. However, the government has promised that other professions allied to medicine will be able to prescribe as of 2004.

Training for supplementary prescribing is based on that for extended independent prescribing. For nurses, the taught element of the course is 26/27 days, of which a substantial proportion is face-to-face contact time, although, other ways of learning, such as open and distance learning (DL) formats, might be used. Students are also required to undertake additional self-directed learning and 12/13 days learning in practice with a medical prescriber.

Training for extended independent prescribing is combined with that for SP in the majority of HEIs. The Royal Pharmaceutical Society of Great Britain (RPSGB), responsible for validating SP programmes for pharmacists has acknowledged that as between 60% and 70% of the SP curriculum will be common to both nurses and pharmacists, institutions running the SP curriculum for nurses provide an ideal opportunity for shared learning. Therefore, a number of HEIs run the combined extended independent/supplementary prescribing programme for nurses and pharmacists. Nurses qualify as both extended independent and SPs upon successful completion of the course and pharmacists qualify as SPs.

In England, the extended independent prescribing module attracts 20 credit accumulation and transfer scheme (CATS) points at level 3. The combined extended

SP programme awards an additional 10 credit accumulation and transfer scheme (CATS) points, i.e. a total of 30 CATS points. This is in contrast to regions with devolved governments (e.g. Northern Ireland). In these instances, HEIs are able to award a greater number of credits. One such institution in Northern Ireland is currently awarding 60 CATS points to nurses undergoing prescribing preparation.

Entry requirements for extended independent and SP programmes include:

- Registration with the NMC as a first level Nurse or Midwife or, for pharmacists, current registration with the RPSGB and/or the Pharmaceutical Society of Northern Ireland (PSNI).
- The ability to study at level 3.
- At least 3 year's post-registration clinical nursing experience (or part-time equivalent). For pharmacists, the level of relevant knowledge and expertise is dependent upon the nature of their practice and the length of their experience.
- Have a medical prescriber willing to contribute to the students 12/13 days learning in practice (including the assessment process), and supervised prescribe post-qualifying.
- Agreement by their employing organisation to undertake the programme, a period of supervised practice, and continuing professional development (CPD).
- Commitment by their employer to enable access to prescribing budgets and other necessary arrangements for prescribing in practice.
- Occupy a post in which they are expected to prescribe (RPSGB, 2003; ENB, 2001).

For further discussion of supplementary prescribing see Chapter 2.

CONCLUSION

Until recently, the development of non-medical prescribing has been slow. It was first considered by the government for nurses in 1986. However, as of 2001, the introduction of extended independent and SP has been considered for other healthcare professionals (including other 1st level nurses as well as those with a DN/HV qualification).

Training for independent extended prescribing for nurses commenced in 2002. Nurses are now able to prescribe independently from a list of medicines (including CDs) for an array of conditions and the government has promised that the NPEF will be further extended to include prescribing in first contact and emergency care. Independent prescribing for pharmacists is currently under consideration.

Training for supplementary prescribing was introduced for nurses and pharmacists in 2003. SPs can prescribe from virtually the whole of the BNF and may include CDs as of 2004. Other groups of healthcare professionals are to be considered by the government for prescribing this year. DoH funding for extended independent and supplementary prescribing has been extended until 2005/2006 and the government aims to train 10,000 nurses and 1000 pharmacists during this period.

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Chapter 2

Non-medical prescribing in a multidisciplinary team context

Barbara Stuttle

The demands by patients for a more streamlined, accessible and flexible service (Department of Health (DoH), 2000), demands for a high quality accountable service and for roles which extend beyond traditional boundaries, acknowledging the range of knowledge and skills held by practitioners and offering them the opportunity to achieve their full potential (DoH, 2001; 2002), has meant that the roles of healthcare professionals have changed dramatically over recent years. These changes have placed a great emphasis on teamwork and multiprofessional co-operation.

The success of non-medical prescribing is dependent upon the contributions from a number of practitioners, including specialist nurses, pharmacists and doctors and the ability of these professionals to work together as a team. This chapter examines the key issues that need to be considered by healthcare professionals if non-medical prescribing is to be implemented effectively. It commences with an exploration of teamwork and then moves on to discuss clinical governance. Communication, sharing information, and supplementary prescribing are then examined.

TEAMWORK

In order to work effectively as a team, a number of key elements are required. These include:

- effective verbal and written communication;
- enabling and encouraging supervision;
- collaboration and common goals;
- valuing the contributions of team members and matching team roles to ability;
- a culture that encourages team members to seek help;
- team structure (Vincent *et al.*, 1998).

Underpinning each of the above elements is the need for team members to have a clear understanding of one another's roles. As non-medical prescribing has changed the role boundaries of professions allied to medicine, so the roles and relationships between healthcare professionals have changed. For example, the

nurse adopting the role of prescriber affects the role of the pharmacist. The conversations surrounding medicines that once took place between the pharmacist and the doctor, now take place between the pharmacist, doctor and the nurse.

Conversely, it is important that the nurse is aware of the support the pharmacist is able to provide. This support will vary depending upon the environment within which the pharmacist works. If the pharmacist is working in a hospital setting and as a member of the ward team, they will have greater information about the patient's conditions and specific problems. The role of the pharmacist is therefore enhanced. As well as the interpretation of prescriptions, checking drug dosage levels, and monitoring prescriptions for possible drug interactions, they may well be able to advise colleagues on a number of topics in relation to drug therapy, undertake medication reviews, discharge planning, education and training (Downie *et al.*, 2003). Furthermore, with the introduction of supplementary prescribing, pharmacists may well be leading clinics such as anticoagulation or pain control clinics and so be able to provide the nurse with a greater wealth of information.

Another area in which confusion may occur, if roles are not fully understood, is level of competency. For example, the ability of a nurse to prescribe, means that they are able to carry out a complete episode of care. However, not all nurses within a team are qualified to prescribe. Therefore, there may be a lack of consistency or continuity of care if other non-nurse prescribers care for the patient. Unless these different levels of competency with regards to prescribing are understood between team members, this could result in inequity of service and confusion for the patient.

The advent of non-medical prescribing, has therefore emphasised the need to clarify the activity of team members, i.e. those activities common to some professions, and those specific to the role of one discipline only. It has been suggested that without this clarity, team members might drift towards common ground and some areas of practice could become neglected (McCray, 2002).

The core values of multidisciplinary work have been described as trust and sharing (Loxley, 1997). An essential component of these values is that trust and sharing are a two-way process. Not only does the team rely on the individual's commitment to the task, but also, members must take on the teams' belief in one's self and meet their expectations. If members of the team are to trust one another and share their experiences, confidence and a clear understanding of one's own professional role is essential (Loxley, 1997).

For example, nurses have traditionally been seen as semi-autonomous practitioners working within the guidelines set by doctors. Medical staff have been seen as those making autonomous decisions and advising on practice. Some professions allied to medicine, for example physiotherapists, although practising autonomously, work primarily on an individual basis with clients. It is suggested by McCray (2002) that power and status, as a result of these differences, may well become an issue and influence trust and sharing when working together in a team. Doctors may well find it difficult to take advice from some healthcare professionals. By contrast, nurses may not feel confident enough to provide advice in relation to their own area of practice.

CLINICAL GOVERNANCE

Clinical governance has been defined as:

> *A framework through which National Health Services (NHS) organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment to which excellence in clinical care will flourish.*
>
> Scally and Donaldson (1998)

Clinical governance has been responsible for bringing professionals together as a multiprofessional team, to collaborate and learn from each other. This has meant moving away from a culture of self-protection and blame, to one where self-regulation and learning through experience is valued (Jasper, 2002). By working together and reflecting on the skills and knowledge of team members, the opportunities for progress and improvement in patient care are immense. The Bristol Royal Infirmary Inquiry (doh.gov.uk/bristolinquiry) and Victoria Climbie (http://www.victoria-climbie-inquiry.org.uk/finreport/finreport.htm) provide examples of where teamwork and communication have broken down. Recommendations from these reports focus on team working, communication, sharing information and joint learning.

Drug therapy is becoming increasingly complex. Many patients receive multiple drugs and therefore, the possibility of error while administering medicines is large. An error that involves the administration of a drug can be a disaster for the patient. Drug administration generally involves several members of the multidisciplinary team and will include a chain of events involving several people, i.e. the manufacturers, distributors, pharmacists, prescribers, hospital managers, and the patients. A number of errors that may occur at each level have been identified by Downie *et al*. (2003). These include:

- Prescribers error:
  - Poor handwriting
  - Abbreviations
  - Confusion of product names that look similar
  - Omission of essential information

- Pharmacist error:
  - Errors in labelling medicines
  - The supply of medicines to wards without information on the actions, dose and use of the product
  - The lack of withdrawal of a product due to fault (i.e. there is a need for rapid communication from pharmaceutical staff to ward staff)
  - Lack of information about a product that is part of a clinical trial: if information is not supplied to ward staff involved in the trial, the product may not be used safely

- Error by the nurse administering the medicine:
  - Misinterpretation of the prescription
  - Selection of the incorrect medicine to be administered
  - Inaccurate record of administration

- Error by the nurse manager:
  - Lack of up-to-date drug information (i.e. British National Formulary (BNF) and local formularies unavailable)
  - No clear lines of communication with clinical pharmacists and Medicines Information Service
  - Inappropriate staff members administering medicines
  - Inaccurate and illegible records regarding the drugs administered
  - Unsafe storage of medicines
  - Lack of withdrawal of medicines when no longer required
  - No consideration to timing and number of medicine rounds
  - Prescribing and recording documents not of the required standard and inappropriate for the area of practice
  - Procedures used in the event of a drug error seen as a deterrent by nurses, i.e. a 'blame' culture
  - An absence of a multidisciplinary drug and therapeutics committee to review medicines management issues
  - Level of risk not assessed (i.e. some drugs more complicated to administer than others)

- Patient error:
  - Lack of co-operation by the patient in order to achieve therapeutic benefits of the drug
  - The rejection of treatment by the patient as a result of a lack of understanding (by the patient) about the drug therapy.

Clinical governance is a useful tool that can be used by the multidisciplinary team to maintain and improve the quality of non-medical prescribing and demonstrate that prescribing practice is in the best interest of the patient. It should ensure that each member of the prescribing team (i.e. doctor, nurse and pharmacist) recognise their role in providing high quality patient care, and how the team can work together to improve prescribing standards.

Regular team meetings provide a forum in which members of the multidisciplinary team can work together to achieve common goals, and develop standards of care and protocols for prescribing. Within these meetings, awareness needs to be raised with regards to such systems as the Yellow Card Scheme for the spontaneous reporting of suspected adverse drug reactions by doctors, dentists, pharmacists, coroners and nurses (http://medicines.mhra.gov.uk/) and the National Patient Safety Agency (NPSA), for reporting drug errors (http://www.npsa.nhs.uk/). The NPSA hope that by promoting a fair and open culture in the NHS, staff will be encouraged to report incidents and so learn from any problems that affect the safety of patients. If team meetings raise staff awareness of the NPSA and errors are discussed, this will enable individuals to reflect and learn from mistake and to take the appropriate action to prevent it happening again. There will be a move away from a 'blame' culture, and patient safety will be increased.

Once standards of care have been set and implemented by members of the multiprofessional team, the team will be able to undertake periodic audits of prescribing practice. The outcome of these audits can be used to identify areas of prescribing practice that require improvement, and also the education and training