Extended prescribing power in diabetes: A landmark for nurses

Molly Courtenay, Nicola Carey

Recommendations were first made in 1986 for nurses to take on the role of prescribing (Department of Health [DoH], 1986). Eight years later (although limited to district nurses and health visitors), nurses in eight demonstration sites throughout England began to independently prescribe (Morris, 1994). There are now approximately 29 000 district nurses and health visitors (DoH, 2005a) qualified to prescribe from the list of appliances, dressings, Pharmacy, General Sales List items, and 13 Prescription Only Medicines included in the Nurse Prescribers' Formulary for Community Practitioners (British Medical Association and Royal Pharmaceutical Society of Great Britain, 2006). This article explores recent advances that have further increased the prescribing power of nurses, namely nurse independent prescribing and nurse supplementary prescribing.

Over the past 20 years, the responsibility for the care of people with diabetes has shifted away from hospitals into primary care. During this time, randomised controlled trials have shown that if regular review of people with diabetes is guaranteed, the standard of primary care can be as good as, or better than, that of hospital outpatient care in the short term (Goyder et al, 1998). Furthermore, it is evident that if these people with diabetes receive education from a specialist nurse, there are additional benefits to be gained. These include reduced length of hospital stay, lowered HbA_{1c}, attainment of treatment targets, and reduced mortality (Peters et al, 1995; Goyder et al, 1998; Cavan et al, 2001; Renders et al, 2001; Young et al, 2002; Davidson, 2003), as well as improved patient satisfaction and self-regulation, and increased knowledge of diabetes (Aubert et al, 1998; Davies et al, 2001; Vrijhoef et al, 2001; Vrijhoef et al, 2002).

The National Service Framework (NSF) for diabetes (Department of Health [DoH], 2003a) focuses on structured, proactive care to support people with diabetes in managing their condition. The role of the nurse in service delivery for people with diabetes is emphasised by this framework. It is evident that, with regard to the management of medicines, nurse specialists in diabetes care have a role to play. For some time, these nurses have been adjusting insulin dose or oral hypoglycaemic medication and therefore have been making decisions related to prescribing (Cradock and Avery, 1998; Winocour et al, 2002; Padmore, 2005). This role developed in recognition of the fact that access to healthcare professionals who are skilled in insulin therapy is vital in order to reduce long-term complications and improve hospital bed states (National Institutes of Health, 2001).

Nurse prescribing, therefore, is one way of ensuring that structured, supportive care is

Article points

1. Nurse specialists in diabetes have for some time been adjusting insulin dose or oral hypoglycaemic medication and therefore have been making decisions related to prescribing.
2. There are a number of benefits to be gained by appropriately qualified nurses adopting the role of nurse independent and nurse supplementary prescriber.
3. Although nurses are now able to prescribe any licensed medicine independently, supplementary prescribing offers additional benefits to nurses working in the area of diabetes.

Key words

- Independent prescribing
- Supplementary prescribing
- Clinical Management Plan

Molly Courtenay is a Reader in Prescribing and Medicines Management, University of Reading, Reading, and the Royal College of Nursing Prescribing and Medicines Management Adviser. Nicola Carey is a Senior Research Fellow, School of Health and Social Care, University of Reading, Reading.

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1. The introduction of independent extended prescribing in 2002, and supplementary prescribing in 2003, has expanded the prescribing powers of nurses.
2. Nurses qualified as nurse independent prescribers are able to assess, diagnose and prescribe independently any licensed medicine described in the British National Formulary apart from controlled drugs.
3. Supplementary prescribing takes place following an initial assessment and diagnosis of a person's condition by a doctor. A Clinical Management Plan (CMP) is then drawn up for the patient.

provided to people with diabetes in both primary and secondary care settings (Hallworth, 2004). Through the increased use of flexible skills, independent and supplementary prescribing should optimise the role of the nurse and ensure that care is better and more convenient for people with diabetes.

Nurse independent and nurse supplementary prescribing

The introduction of independent extended prescribing in 2002 (DoH, 2002), and supplementary prescribing in 2003 (DoH, 2003b), has expanded the prescribing powers of nurses. Any appropriately qualified registered nurse is now able to prescribe medicines. Nurses qualified as nurse independent prescribers are able to assess, diagnose and prescribe independently any licensed medicine described in the British National Formulary (BNF) apart from controlled drugs (DoH, 2005b).

In contrast, supplementary prescribing takes place following an initial assessment and diagnosis of a person's condition by a doctor. A Clinical Management Plan (CMP) is then drawn up for the patient. This plan, agreed by the patient, nurse and doctor, includes a list of medicines (within the supplementary nurse prescriber's area of competence) from which the supplementary prescriber is able to prescribe. Supplementary prescribers are able to prescribe any medicine (including controlled drugs and unlicensed medicines) but this form of prescribing is best suited to patients with long-term healthcare needs.

Education and training

Training and education for nurse independent and nurse supplementary prescribing is combined. Nurses registering to undertake this training must be able to study at degree level and have at least 3 years' experience as a qualified nurse (Nursing and Midwifery Council [NMC]; 2001). The prescribing course is between 3 and 6 months in length. It comprises a 27-day classroom component (although other ways of learning, such as open- and distance-learning formats, are available at some universities) and 12 days of learning in practice with a designated medical practitioner.

Topics covered during the classroom component include (NMC, 2001):

- 'Legal, policy and ethical aspects'
- 'Professional accountability and responsibility'
- 'Prescribing in the public health context'
- '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'
- 'Evidence-based practice and clinical governance in relation to nurse prescribing'.

Upon successful completion of the programme, students are awarded the dual qualification of Nurse Independent and Nurse Supplementary Prescriber. There are now over 8000 nurses qualified to prescribe as both independent and supplementary prescribers (personal communication, NMC).

The benefits of nurse prescribing

The impact and effectiveness of nurse prescribing has largely meant that it has been a positive development (Latter and Courtenay, 2004). Advantages reported by district nurse and health visitor prescribers include an increased sense of satisfaction, status and autonomy, time savings, convenience, continuity of care, cost-effectiveness, improved communication and a belief that patients receive better information from nurses about prescriptions (Luker et al, 1997; Luker et al, 1998; Rodden, 2001; Lewis-Evans and Jester, 2004). Disadvantages reported include concerns about patient diagnosis, and anxiety about writing a prescription (Luker et al, 1997; Luker et al, 1998).

Several studies (Larsen, 2004; Bradley and Nolan, 2004; Bradley et al, 2005; Latter et al, 2005; Berry et al, 2006) have examined independent extended and supplementary nurse prescribing. Advantages reported by nurses adopting this role include greater satisfaction and autonomy, less dependence upon doctors, the ability to deliver complete episodes of

care, better use of nursing skills, increased prescribing knowledge, increased autonomy and accountability, and increased access, for patients, to services. Several disadvantages have been reported by nurses adopting these modes of prescribing. These include the increase in responsibility, the abuse of the prescribing role by colleagues through misunderstanding, a lack of support once qualified, increased workload, and the effects on the role of the nurse (that is, a move towards a medical model of care to the detriment of other aspects of nursing care such as health promotion).

A number of benefits of independent extended and supplementary nurse prescribing have also been reported by doctors (Avery et al, 2004; Latter et al, 2005). These benefits include improved professional relationships, a means of refreshing doctors' own knowledge, fewer interruptions to sign prescriptions, and reduced workload. However, a disadvantage reported is the level of commitment required of doctors in order to supervise nurses adopting the prescribing role. There is a feeling among some doctors that they should be financially rewarded for their involvement.

Nurse prescribing in diabetes

For nurses caring for people with diabetes, the introduction of independent and supplementary prescribing represents an important landmark. Prescribing will ensure that these nurses are better able to utilise their skills and are not reliant upon the doctor for the signing of a prescription. It will ensure that people with diabetes will be able to access their medicines faster and more conveniently, and receive a complete episode of care from the nurse. Additionally, prescribing knowledge gained through the prescribing programme will enable nurses to provide patients with better information about their medicines.

Supplementary prescribing offers a number of additional benefits. This mode of prescribing, with its emphasis on concordance, is an ideal framework within which nurses can prescribe for long-term conditions such as diabetes. A big advantage is that prescribing decisions are supported from the sound evidence base made available through the CMP. Additionally, in a supplementary prescribing arrangement it is the doctor who is responsible for the assessment and diagnosis of the person's condition. This mode of prescribing will therefore enable nurses to develop their prescribing skills, and thus act as a stepping stone to full independent prescribing.

Added to this, many people with diabetes have multiple pathologies. Nurses may well feel unhappy prescribing independently for these other conditions and the associated polypharmacy issues. As long as the nurse works in close partnership with the doctor and has access to the medical records and to a prescribing budget, this mode of prescribing should work extremely well when caring for a person with diabetes who has multiple pathologies.

Finally, long-term conditions are areas emphasised in the Quality and Outcomes Framework. It is in these areas that supplementary prescribing and the CMP provides an ideal framework through which practices are able to achieve and maintain the quality indicators. For example, the attendance of people with diabetes at the supplementary prescriber's clinic, until good control of the condition is achieved and maintained, enables quality criteria to be met.

Conclusion

Nurse specialists in diabetes care have been making decisions related to prescribing for several years. It is evident that there are a number of benefits to be gained by appropriately qualified nurses adopting the role of nurse independent and nurse supplementary prescriber. These benefits include faster access to medicines for people with diabetes and more effective use of nursing skills. Although nurses are now able to prescribe any licensed medicine independently, supplementary prescribing offers additional benefits to nurses working in the area of diabetes. These benefits include a sound evidence base from which to make prescribing decisions, and a framework within which to prescribe medicines for people with multiple pathologies. ■

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LAN06/168. Date of preparation June 2006