

# Enhancing the DSN role: Independent and supplementary prescribing

Maggie Bodington

Historically, DSNs have been involved in advising on, the prescribing of, administration of, and adjustment of diabetes medication, in varying capacities. In recent years, however, a formal training qualification has been available in the UK to allow nurses to prescribe legally as supplementary or independent prescribers. This article explores the legislation pertaining to nurse prescribing and advises DSNs on what the prescribing qualification involves. Responsibility and accountability are discussed and the different types prescribing are defined, with a focus on continuing professional development and the implications of nurse prescribing for practice.

Nursing has evolved considerably over the past 20 years as nurses have extended their existing roles, taken on new roles and become more specialised. Greater autonomy and responsibility for nurses was enabled further by *The NHS Plan* (Department of Health [DH], 2000), which promised to create new roles, extend existing roles and responsibilities for nurses and other non-medical professions. Some nurses, because of their experience, may have developed into these extended roles often without extra training and consideration of the legal and ethical issues.

This article details the history to non-medical prescribing, defines the different types of prescribing, and outlines the practicalities of how to become an independent or supplementary nurse prescriber.

## Background

In 2006 the Nursing and Midwifery Council (NMC) set out some prescribing practice standards:

- Nurses are accountable for all their prescribing decisions, including omissions, and they

cannot delegate this responsibility to another person (practice standard 2).

- If they delegate the administration of the medication to another they are still accountable for what they have prescribed (practice standard 14).
- The principles of good record keeping to be upheld, include maintaining accurate, comprehensive, contemporaneous records that are accessible by all the prescribing team members (practice standard 7).

It is also important for nurses to ensure they have some indemnity insurance cover in place (NMC, 2006).

DSNs and practice nurses (PNs) have historically been involved in diabetes medicine management, advising on medication adjustment and administration as part of their job description, but without formal training or qualification. Some PNs may have felt under pressure as more responsibility and autonomy was afforded and expected of them, including a prescribing role. In contrast, some nurses may have welcomed the increased autonomy, foreseeing it as improvement in efficiency and

## Article points

1. DSNs have historically been involved in diabetes medicine management, advising on medication adjustment and administration as part of their job description, but without a formal training or qualification.
2. From May 2006, qualified independent and supplementary prescribers have been able to prescribe any licenced medicine within their area of competence.
3. Nurse prescribing courses now lead to the dual qualifications of independent and supplementary prescriber.
4. Undertaking the training to qualify as an independent and supplementary prescriber provides the legal framework for nurses to prescribe for people with diabetes.

## Key words

- Independent prescribing
- Non-medical prescribing
- Nurse prescribing
- Supplementary prescribing

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1. Following the Crown Report, funding was made available for the training of registered nurses to prescribe independently from an extended formulary, leading to the introduction of independent extended formulary nurse prescribing in 2002 and supplementary prescribing in 2003, initially for registered nurses, midwives and pharmacists, and later for chiropodists, physiotherapists and radiographers.
2. Part of *The NHS Plan* was to extend the role of nurse prescribing, and from May 2006 qualified independent and supplementary prescribers have been able to prescribe any licensed medicine within their area of competence.
3. With the rising numbers of people with diabetes and more nurse-led diabetes services there is increasing pressure on nurses to extend their prescribing responsibility.

access to care for their patients (Courtenay et al, 2007). There are still many nurses specialising in diabetes care who have not undertaken non-medical prescribing training.

A survey was undertaken by Diabetes UK and NHS Diabetes in September 2009 for the compilation of a DSN workforce database. Of the 1363 DSNs and nurse consultants who were sent the survey questionnaire, 838 (61%) responded, but only 40% had a non-medical prescribing qualification (Gosden et al, 2010).

**Non-medical prescribing legislation**

The *Review of Prescribing, Supply and Administration of Medicines* (DH, 1999) – the “Crown Report” – reviewed the prescribing, supply and administration of medicines. From this report the legal framework that is in effect today for medical and non-medical prescribing originated in the form of independent and supplementary prescribing.

The term “prescribe”, in the legal sense, as used in the *Medicines Act 1968*, was cited in the Crown Report (DH, 1999):

*(i) to order in writing the supply of a prescription only medicine for a named patient; but commonly used in the extended sense of:*

*(ii) to authorise by means of an NHS prescription the supply of any medicine (not just a prescription only medicine) at public expense; and occasionally:*

*(iii) to advise a patient on suitable care or medication (including medicine which may be purchased over the counter).”*

Prescribing does not just mean writing a prescription form and signing. It could involve a recommendation to adjust the dose, timing or means of administration of a medication previously prescribed by an independent prescriber. Writing a dose change in the record book of a person with diabetes or writing of a referral to a community nurse to administer or alter insulin are also forms of prescribing.

Some nurses (mainly district nurses and health visitors) have been able to prescribe

from a limited list of medicines, appliances and dressings since 1992 (*Medicinal Products: Prescription by Nurses etc. Act 1992*). Following the Crown Report, funding was made available for the training of registered nurses to prescribe independently from an extended formulary, leading to the introduction of independent extended formulary nurse prescribing in 2002 and supplementary prescribing in 2003, initially for registered nurses, midwives and pharmacists (DH, 2003), and later for chiropodists, physiotherapists and radiographers (DH, 2005).

Part of *The NHS Plan* was to extend the role of nurse prescribing, and from May 2006 qualified independent and supplementary prescribers have been able to prescribe any licensed medicine within their area of competence (DH, 2006a).

Nurses involved in diabetes care can have very different roles. Diabetes can be a part of their role, as in the case of some PNs, or their main role, as may be the case with DSNs. They may be employed with very different contracts and expectations from their employers, and therefore work in different ways. Some of these nurses will be very experienced, have a high degree of expertise and feel very confident about taking on a prescribing role, but others not so.

With the rising numbers of people with diabetes and more nurse-led diabetes services, there is increasing pressure on nurses to extend their prescribing responsibility. Prescribing is a very powerful tool for healthcare professionals (Avery and James, 2007) and can enhance patient care, and access to, and continuity of, care. However, it is also a cause of patient harm, hence the need for the training, knowledge and expertise to prescribe competently (Smith, 2004).

The NMC (2006) set out the standards for prescribing practice:

*“You may only prescribe once you have successfully completed an NMC approved programme and recorded this in the NMC register.” (Standard 1)*

There has been an increasing shift in diabetes care from secondary to primary care and, because of the need for specialist expertise, many DSNs are moving to work in primary care, where the majority of non-medical prescribers are based (Courtenay and Carey, 2008a). In some PCTs there is a mentorship arrangement for DSNs with the specialist doctors in secondary care, but for many nurses there is no such arrangement. GPs may have little experience in diabetes management and the diabetes nurses working in general practices may be undertaking the assessment, diagnosis, treatment and management of patients.

Some nurses may welcome this increased autonomy and responsibility but some may feel isolated. This can impact on a nurse's confidence to prescribe and may prevent them from prescribing compared with working in teams where there is more peer support (Otway, 2002; Latter et al, 2005; Courtenay and Carey, 2008b). This highlights the need for accessible, formal and, most importantly, appropriate clinical supervision or mentoring.

### Patient Group Directions, supplementary and independent prescribing

Most readers may have heard of Patient Group Directions (PGDs), supplementary and independent nurse prescribing (formerly called extended formulary nurse prescribing), but some may not know fully what these terms mean and how they apply in practice.

#### Patient Group Directions

PGDs are defined by the DH (2005) as:

*“Written instructions to supply and administer medicines to groups of patients, not individually identified prior to treatment.”*

PGDs relate to the supply and administration of a medicine, and not actually prescribing. As an example, PGDs are used frequently in immunisation programmes where a fixed dose is administered. PGDs are not generally very useful for diabetes management because they cannot be

used for adjusting insulin or oral therapies, but may be used for the administration of glucagon in emergency situations.

#### Supplementary prescribing

Supplementary prescribing is defined by the DH (2005) as:

*“A voluntary partnership between an independent prescriber (doctor or dentist) and a supplementary prescriber (e.g. nurse, midwife, pharmacist, who has completed the relevant training) to implement an agreed, patient-specific, clinical management plan (CMP) with the patient's agreement.”*

The diagnosis is made by the independent prescriber, and under arrangements for supplementary prescribing the independent prescriber must be a doctor. The CMP is drawn up with the agreement of all parties – the patient, the doctor and the supplementary prescriber – before prescribing can take place. The supplementary prescriber can then prescribe all medication detailed on the CMP (DH, 2006a; 2006b). The CMP is patient-specific and will include a list of medicines from which the supplementary prescriber can prescribe if the medicines are in the nurse's area of competence.

Supplementary prescribing means that time spent initially developing a plan for each patient would be future time saved when the person can be reviewed by the supplementary prescriber, rather than the doctor, hence providing a more efficient, quicker service for the individual. This can sometimes be useful in primary and secondary care diabetes settings, for example when people with diabetes come back for reviews in nurse-led clinics.

However, some may argue that the implementation of the CMP can be a barrier, preventing this mode of prescribing, because of the administrative requirements involved in the preparation of the plan, which nurse prescribers may find a problem (Courtenay et al, 2007). The NMC (2009) stresses that CMPs must not be used as a “blanket

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authority” to prescribe medication for all patients within an organisation who have the same condition:

*“If an independent prescriber agrees in advance that the supplementary prescriber can prescribe for a patient, by virtue of them being on an agreed practice register and using the same CMP for all patients and then incorporating these into the patient’s computer records, this is illegal practice and does not meet clear legislative requirements.”*

The NMC’s concerns are that because CMPs can be complex, some nurses may generate prescriptions for the doctor to sign, without the doctor having assessed the patient. Although the doctor may be ultimately accountable, the nurse remains responsible for what he or she has generated on the prescription, and would be in a vulnerable position, as this would be considered poor practice (NMC, 2009).

#### Independent prescribing

Independent prescribing is defined by the DH (2006b) as:

*“Prescribing by a practitioner (e.g. doctor, dentist, nurse, pharmacist) responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing. Within medicines legislation the term used is ‘appropriate practitioner’.”*

From May 2006, extended formulary nurse prescribers became nurse independent prescribers, as instead of working from an extended formulary, nurse independent prescribers were able to prescribe any licensed medicine for any medical condition within their competence. These include some controlled drugs for specified medical conditions (NMC, 2006, standard 17.1), and in December 2009 *The Medicines for Human Use (Miscellaneous Amendments) (No.2) Regulations 2009 (No. 3063)* authorised nurse and midwife independent prescribers to prescribe unlicensed medicines for those in their care, with certain provisos. A circular to this effect was issued by the NMC in March 2010 (DH, 2010).

Under independent prescribing it is the independent prescriber who is responsible for the diagnosis and prescribing. With supplementary prescribing it is also the independent prescriber who makes the diagnosis, but in this scenario the independent prescriber must be a doctor or a dentist (DH, 2005).

**Box 1. Nursing and Midwifery Council (2006) criteria for eligibility to undertake the independent and supplementary prescribing programme.**

- You must be a registered first level nurse, midwife and/or specialist community public health nurse.
- You must have at least 3 years' experience as a practising nurse, midwife or specialist community public health nurse and be deemed competent by your employer to undertake the programme. Of these 3 years, the year immediately preceding application to the programme must have been in the clinical field in which you intend to prescribe.
- Part-time workers must have practised for a sufficient period to be deemed competent by their employer.
- You must provide evidence, or via the Accreditation of Prior and Experiential Learning process of your ability to study at minimum academic level three degree.
- In addition, you will need to have written confirmation from your employer of their support for you to undertake the preparation programme, and the programme lead about your selection onto the preparation of prescribers education programme. This should also be given to you and your employer.
- A designated medical practitioner who meets the eligibility criteria for medical supervision of nurse prescribers and who has agreed to provide.

**Box 2. Nursing and Midwifery Council (2006) assessment strategies for nurse independent/supplementary prescribers.**

- A portfolio or learning log that demonstrates application of theory to practice, and provides rationale for prescribing decisions and reflective practice. It should include evidence of numeracy skills, writing prescriptions and prescribing in a range of scenarios.
- Either an Objective Structured Clinical Examination, which is a systematic and detailed examination of practice within a simulated learning environment, or a systematic and detailed examination of practice in a setting relevant to the registrant's area/field of practice, or a video consultation in a live practice setting. It will be the responsibility of the registrant and the designated medical practitioner to ensure that necessary legal requirements are obtained for consent from patient/clients.
- Satisfactory completion of the period of practice experience, including sign-off by the designated medical practitioner and the employer, that the student is competent to prescribe medicines in their area of practice.
- A written final examination that consists of a total of twenty, short answer and multi-choice questions to test pharmacological knowledge and its application to practice. Students must achieve a minimum 80% pass.
- A numerical assessment within the context of prescribing practice. Students must achieve a 100% pass.

If a registrant fails to answer correctly any question that may result in direct harm to a patient/client they must be referred.

**Becoming an independent and supplementary nurse prescriber**

DSNs have been advising on diabetes medication for years, all but for the signing of prescriptions. This was an accepted part of their role when no formal qualification was available, but nowadays it may be questionable as to whether such practice is legally acceptable.

The independent prescribing qualification helps facilitate the safety, ethical and legal issues that encompass the prescribing and administration of medicines. Not all nurses involved in diabetes care will necessarily want to be independent prescribers, as they may perceive the increased autonomy as greater responsibility and accountability; however, if a nurse's present practice is legally questionable he or she may be more accountable.

Nurse prescribing courses now lead to the dual qualifications of independent and supplementary prescriber. Courses are available at academic level three and masters level, and the NMC have set standards to validate them. The course is generally 26 days in length, of which a substantial proportion is face-to-face contact time, and 12 practice days delivered over a 6-month period with 100% attendance expected (DH, 2009).

Certain criteria must be met before undertaking a nurse prescribing course (*Box 1*). The DH (2006b) requires that the nurse must:

- Be a first level registered nurse or registered midwife.
- Have valid registration on the NMC professional register.
- Have successfully completed the nurse prescribing preparation.

Proficiency is assessed theoretically and practically, testing knowledge, decision making and application of theory to practice (*Box 2*). In *Box 3* the author discusses her personal experiences of undertaking the course, and of being a DSN independent prescriber in primary care.

**Continuing professional development**

Latter et al (2005) found that 50% of nurses had undertaken CPD in some form since

qualifying as a prescriber. Nearly all the sample, if they had not undertaken formal CPD, had been able to undertake it informally through private study. Encouragingly the majority agreed that they had up-to-date clinical and pharmacological knowledge to diagnose and discuss treatment options.

Carey and Courtenay (2010), in a survey on nurse prescribing in diabetes, found that 80% of 439 respondents (63% of which worked in general practice) were able to access CPD and over 40% had CPD needs in pharmacology for diabetes and its related conditions.

CPD is essential if nurses are to maintain their skills and competencies to prescribe safely and within evidence-based guidelines. DSNs and PNs, especially those working in primary care, now have increasing responsibility for the care of the associated comorbidities of diabetes, including cardiovascular disease, renal impairment, neuropathy, lipid management and psychosocial issues, all of which can impact on prescribing and care planning.

CPD should involve updates on diabetes and its comorbidities, as well as pharmacology. In addition, there are circumstances where skill, experience and judgement have implications not just for when and what to prescribe, but also when and what not to prescribe. One prescription does not “fit all” but some doctors or nurses, perhaps those with less experience, may prefer to stay within their “comfort zones”, prescribing drugs that they have more experience with but not necessarily the most flexible or beneficial regimen for the patient.

Nurse prescribers must be knowledgeable and competent regarding drug pharmacokinetics and pharmacodynamics, and also about what, how and when to prescribe, with awareness of possible contraindications, interactions with other drugs and other pathologies. When making a clinical assessment with a view to prescribing, there may be a need to access the patient’s biomedical data, such as renal and hepatic status, and more importantly be able to interpret that data and understand its significance in terms of safe and effective prescribing.

### Box 3. The author’s experience of prescribing in primary care.

The author, having been a DSN based in secondary care, is now employed by one single general practice, which is the largest in the UK. The patient list size is 36 000 with around 1600 people on the diabetes register. Diabetes care in the practice is nurse-led. The author is employed on a full-time contract and there is one other DSN working 4 days per week and a practice nurse who has one diabetes clinic a week. The DSNs have a good working relationship with the diabetologists and the diabetes team in secondary care.

*“Undertaking the independent and supplementary prescribing qualification gave me reassurance that the medicine management aspect of my role had a more legitimate foundation, as well as making me more aware of the complexities and seriousness of the prescribing role. The course motivated me to improve my knowledge about diabetes and its comorbidities, particularly in relation to pharmacodynamics and pharmacokinetics.”*

With the launch of the British National Formulary in 2006 by the Department of Health (Joint Formulary Committee, 2006) for independent nurse and pharmacist prescribing, the responsibility for clinical competency lies directly with the prescriber. Some nurse prescribers may want to limit their prescribing while undertaking further education or developing clinical skills (Bowskill, 2010).

With the increased autonomy that independent prescribing brings, there can be increased job satisfaction. One can undertake the assessment, diagnosis and discussion about management and treatment options and then, in partnership with the person with diabetes, be able to make appropriate prescribing decisions and, if necessary, write a prescription. The patient experience, access to, and continuity of care is improved. The person with diabetes feels more confident having a consultation with someone who has knowledge and experience of their condition and who can give them an explanation about the rationale behind the treatment, how it works and potential side-effects. A study by Berry et al (2006) found that as long as this was the case, it did not matter whether that person was a doctor or a nurse and the participants in this study were overwhelmingly satisfied and confident about nurse prescribing.

The management and GPs are very supportive of the nurse prescribers within the practice as it enhances the service the practice provides. Diabetes care is more accessible – at times more suitable for the person with diabetes, rather than when a doctor is available. This accessibility extends to people with diabetes in nursing homes and those who rely on community nurses or other carers to administer medication. The nurse prescriber can assess the person with diabetes and prescribe independently.

### Conclusion

Nurses who are involved in advising on medicines for people with diabetes should consider undertaking an NMC-accredited prescribing course. Undertaking the training to qualify as an independent and supplementary prescriber provides the legal framework for nurses to prescribe for people with diabetes; it enhances patient care and increases prescribing confidence for the nurse.

***“Undertaking the training to qualify as an independent and supplementary prescriber provides the legal framework for nurses to prescribe for people with diabetes; it enhances patient care and increases prescribing confidence for the nurse.”***

The training also provides awareness of the responsibilities we have, as nurses, to ensure that our practice is safe, person-centred and evidence-based.

Independent prescribing covers medical and non-medical prescribing and is prescribing by a practitioner responsible and accountable for the assessment of the patient, the diagnosis and the clinical management required, which may include prescribing. Supplementary prescribing involves a voluntary partnership between an independent prescriber (who must be a doctor or dentist), the patient and a supplementary prescriber (for example, a nurse who has undergone relevant training) to implement an agreed, patient-specific CMP. The diagnosis is made by the doctor and a CMP is drawn up for each individual patient.

There can be issues around nurse prescribers feeling isolated as they work more autonomously, so it is important for them to work within supportive teams. Pharmacological interventions for treating diabetes and its comorbidities are constantly changing with increasing research and new evidence, so CPD needs must be constantly addressed. Nurses are in an ideal position for the education and treatment of the majority of people with diabetes and its comorbidities. Having the appropriate skills to combine this care would enable a more efficient, accessible, and cost-effective service. ■

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