Non-medical prescribing: The importance of knowing the evidence base

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The role of the nurse has evolved and continues to evolve in response to the nation's changing health needs. Over the years nurses have taken on more and more responsibilities with regard to patient care and have increased their accountability to ensure they can provide the best evidence-based care.

Historically, DSNs have been enthusiastically involved in non-medical prescribing (NMP). As specialist nurses we strive to ensure the most appropriate medication and treatments are given to meet the needs of the person with diabetes. DSNs have been responsible for the creation of nurse-led clinics, extended diabetes services at GP surgeries and they provide the support needed to deal with the increasing number of people who have diabetes.

When prescribing, nurses should follow the Nursing and Midwifery Council's prescribing practice standards (2006). Nurses are expected to prescribe to the highest standards and they must be accountable for their competency.

Over the past few years there has been an influx of new medications for diabetes. Some older therapies, which had become less popular, have been shown to have the potential to produce the same clinical outcomes as newer treatments at a fraction of the cost (Gordon et al, 2013). Furthermore, the changing evidence surrounding the potential risks associated with medications in the diabetes portfolio is in constant need of consideration.

All diabetes practitioners are walking a tightrope between driving targets down and saving money while also prescribing safely. The question is whether we are managing to do this successfully? I am certainly starting to feel very apprehensive about the growing number of newer medications. I find myself questioning if my prescriptions are still within the guidelines of safe practice and whether I am choosing the most effective medication for the individual sitting in front of me. As independent non-medical prescribers it is vital that DSNs stay ahead of the game. We need to have a good understanding of treatments but we should also surround ourselves with expertise to help us with difficult prescribing decisions.

When we first started the NMP courses, we eagerly visited our medical supervisors, discussed prescribing decisions with course tutors and deliberated over medications with our peers, receiving encouragement and support. We are now in an environment of stretched resources with limited time and fewer opportunities to make decisions in a relaxed learning environment that can help us make the best evidence-based medication choices. Nurses will find it increasingly difficult to find the time to consult doctors or diabetes experts and this will make the profession vulnerable. I am not suggesting any of us are not prescribing appropriately, but I am anxious about the potential risk we put ourselves in by not ensuring we have regular clinical supervision with an appropriate specialist; although, of course, this is less of a problem if the DSN is working in a specialist diabetes centre. The practitioners that are most vulnerable to potential errors are those who work in isolation in general practice running the nurse-led clinics, community matrons, or prison nurses where their peers will not necessarily be diabetes specialists.

It is vital that we are able to choose the best medication for people with diabetes and deliver safe and effective treatment. However, we must make sure the treatments provided are chosen using the same evidence base as our specialist diabetes peers. DSNs must strive to avoid being in a compromised position, which could present difficulties to the both the person with diabetes and to their own accountability. ■

Gordon J et al (2013) Evaluation of insulin use and value for money in type 2 diabetes in the United Kingdom. *Diabetes Ther* **4**: 51–66

Nursing and Midwifery Council (2006) *Standards of Proficiency for Nurse and Midwife Prescribers.* NMC, London. Available at: http://bit.ly/JimwQS (accessed 12.12.13)