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*Supplement Editor*

# Non-medical prescribing for the older population

One of the strategies introduced by New Labour to address the growing economic burden of healthcare on our society was that of nurse prescribing (Department of Health [DoH], 2000). Supporters of non-medical prescribing (as it is now termed) highlight the reduction in waiting times for appointments, the evidence of high quality care by nurses and others working in a limited field, and the relative satisfaction of the public which appears to accompany this mode of prescribing (Day, 2003). There is little doubt that, in certain areas, non-medical prescribing can enhance patient care and it was envisaged that supplementary prescribing would be most useful in the areas of chronic disease management. However, diabetes specialist nurse (DSN) prescribers need to be mindful of the type of patients who may or may not benefit from supplementary prescribing and clinical management plans.

## Prescribing for older people

Prescribing for certain groups may be particularly hazardous and prescribing for older people is especially problematic. Older people have multiple morbidity and multiple pharmacology (Hughes, 1998a; Kirkland, 2000) making prescribing for these people intricately complicated, raising a number of safety issues. The DSN with supplementary prescribing qualifications is in an ideal position to review the needs of the older person with diabetes. Although some old people may be psychologically sound and very capable of following a medication regime, there are other issues needing consideration in this population group. Hughes (1998b) highlights the fact that ageing is associated with pharmacokinetic and pharmacodynamic changes. Impairment of homeostatic mechanisms (changes in absorption, body composition, elimination and metabolism) together with the effect of multiple pathology can cause a significant increase in sensitivity to some drugs and an increase in adverse reactions.

The nursing philosophy is one of holistic care and diabetes nurses frequently manage the long-term complications of this chronic disease which may include renal, nerve, cardiovascular, ocular and autonomic systems. Also, by the very nature of the disease, a patient with diabetes often takes multiple drugs to control or prevent complications. Regrettably, in spite of the fact that there is an increasing awareness of these facts among the medical profession, action has been slow in reducing the degree of inappropriate polypharmacy which increases with advancing age (Griffin and Chew, 1990; Purves and Kenny, 1994). Furthermore, Kesson and Knight (1990) argue that prescribing more than three medicines for any older person may result in none of the drugs being taken correctly. A DSN already takes a detailed history of all patients referred and drug reviews form an integral part of the assessment which diabetes nurses carry out. Therefore, as a supplementary prescriber, he/she is ideally placed to review all medications, discuss any issues with the independent prescriber and check for compliance with the patient.

## Understanding advice

Complying with advice is a thorny issue. From my own experience, older patients are frequently unsure of the name of their drugs, take them incorrectly, or not at all, and fail to relate this fact to their doctors. Nor do they reveal other drugs which they may be taking, such as homeopathic, 'over-the-counter' drugs and drugs which may have been prescribed for other family members. This has sometimes resulted in drug doses being increased, or further medication being added to existing

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regimen because patients have not liked to admit that they were not taking their prescribed drugs. Clearly, patients are unaware of the possibility of drug accumulation in the body and the potential danger of their actions.

The *National Service Framework for Older People* (DoH, 2001) states that we need to:

> ***'ensure older people are supported by newly integrated services with a well co-ordinated, coherent and cohesive approach to assessing individual's needs and circumstances'.***

Due to the fact that consultation periods with DSNs are necessarily longer than most doctor consultations when reviewing metabolic control, the opportunity arises whereby patient compliance can be assessed and instructions can be repeated several times if necessary, then rechecked for patient understanding.

## Achieving concordance

Involving patients in the decision-making of their care is more likely to achieve concordance. Concordance implies negotiation and is replacing the term compliance, which in itself implies 'force'. The National Service Framework for diabetes (DoH, 2002) has emphasised the concept of patient empowerment, which sits comfortably with a negotiated contract. Likewise, the Medicines Partnership (2003) suggests, in order to effectively achieve concordance, patients must have sufficient knowledge, they must be treated as partners in the consultation and they must be supported in taking their medicines, which includes a regular review of all medicines taken.

Diabetes nurses require highly effective negotiating skills, particularly where older patients need insulin therapy, as many either refuse to take insulin, or are antagonistic towards the concept. Effective consultation focuses on a two-way partnership between the healthcare professional and the patient, with an emphasis on the patient's perspective (Gask and Usherwood, 2002; Pendleton et al, 2003). It is this negotiation which features strongly in supplementary prescribing and also in the diabetes nurse's consultations with his/her patients. Negotiation ensures that the patient gains maximum effect from his/her medication (National Prescribing Centre [NPC], 2000; NPC, 2003) and, I would also argue, determines the patient's own wishes and desires. Achieving concordance is also likely to increase the margins of safety for the patient.

## Conclusion

Keeping drug therapy to a minimum in the older person helps to ensure the safety of the patient and efficacy of the drugs involved. Fliser and Ritz (1996) emphasise that inappropriate prescribing includes both overuse and underuse of drugs. The MeReC (NPC, 2000) reinforces this philosophy and recommends that drugs should only be prescribed for the older person if they are essential and therefore a regular review is crucial to the patient's safety.

Supplementary prescribing provides an ideal opportunity for DSNs to complement the care of their patients, provided that they work within their own skills and knowledge boundaries and know when to refer patients back to the independent prescriber. However, support from the independent prescriber, management, the prescribing lead and other members of the multidisciplinary team is essential not only to the success of supplementary prescribing (Courtenay and Griffiths, 2004) but also to improve the care of patients, and especially those from vulnerable groups. Forums such as clinical supervision, multidisciplinary team meetings and nurse prescribing meetings could provide the type of support necessary, particularly for the nurse new to prescribing. Supplementary prescribing could be a welcome addition to the diabetes nurse's role, especially for elderly patients, but I would argue that the appropriate support mechanisms need to be in place first. ■


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