

Supplementary nurse prescribing: Considerations for older people

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ARTICLE POINTS

1 Supplementary prescribing is still in its infancy and many nurses are currently using Patient Group Directions.

2 There is a range of conditions that affect prescription choice – particularly in older people (e.g. renal function, body mass, polypharmacy and drug sensitivity).

3 The supplementary prescribing course may be the first opportunity a nurse has had to study the effect of drugs on older people in any depth. Hence, his/her prescribing may be safer after the course.

4 Rather than prescribing, it may be argued that more important in caring for older people with diabetes is use of core nursing skills (e.g. empathy and listening).

KEY WORDS

- Older people
- Prescribing
- Patient Group Directions
- Safety

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Introduction

This article explores the advantages and disadvantages of supplementary nurse prescribing, particularly in relation to older people requiring chronic disease management. The article also looks at the supplementary prescribing process and the training needed to become a supplementary prescriber, and questions whether all specialist nurses on a team need to train to become supplementary prescribers. Finally, the article considers the associated safety, legality and resourcing issues.

Supplementary prescribing is still in its infancy and many nurses are currently functioning to the agreed standards of Patient Group Directions (PGDs). There is no doubt that, in many areas, supplementary prescribing can be of great benefit to people with diabetes, but there are arguments that it is not an essential tool for all. This article will explore the advantages and disadvantages of supplementary nurse prescribing, particularly in relationship to older people requiring chronic disease management, and highlight areas which need to be considered by teams before making the decision that all specialist nursing staff should undergo training.

The history of nurse prescribing

The NHS Plan: A plan for investment, A plan for reform (Department of Health [DoH], 2000) emphasised the necessity to organise and deliver services around the needs of patients. In order to achieve this, traditional demarcations between clinical roles have been – and will be further – broken down to allow clinical professionals to work more flexibly for the benefit of patients. One area in which traditional barriers are being removed is in the area of prescribing.

The debate relating to nurse prescribing has been discussed and argued for the last 15 years. Since 1994, suitably trained district nurses and health visitors have been able to prescribe from a limited list of items (outlined in the *Nurse Prescribers' Formulary for District*

Nurses and Health Visitors and the Nurse Prescribers' Extended Formulary; British Medical Association [BMA] and Royal Pharmaceutical Society of Great Britain [RPSGB], 2005).

Supplementary prescribing was then introduced in April 2003 and is currently available for nurses and pharmacists (DoH, 2003). It is a voluntary prescribing partnership between the independent prescriber (doctor) and supplementary prescriber (SP; currently a registered nurse or pharmacist) to implement an agreed patient-specific Clinical Management Plan (CMP), with the patient's agreement (DoH, 2003).

Following agreement of the CMP, the SP may prescribe any medicine for the patient that is referred to in the plan, until the next review by the independent prescriber. This is usually done annually, although the SP can pass prescribing responsibility back to the independent prescriber if the clinical reviews are not carried out within the specified interval or if they feel that the patient's condition no longer falls within his/her competence (DoH, 2003) – for example, the older person with diabetes may also encounter other co-morbidities.

Unlike independent nurse prescribing, there is no formulary specifically for supplementary prescribing, and no restrictions on the medical conditions that can be managed under these arrangements (DoH, 2003).

Supplementary prescribing is most useful in

the following circumstances:

- For people with long-term conditions who can be managed by a nurse or pharmacist between medical reviews
- When nurses or pharmacists are competent to manage a patient's condition
- Where there is a close working partnership between the independent prescriber and the SP, and the SP has access to the same common patient record.

Should all DSNs be nurse prescribers?

Nurse-led care of people with diabetes, particularly older people with diabetes, has always been an integral part of the role of diabetes specialist nurses (DSNs). Diabetes service needs have changed dramatically in the last 15 years and the role of the DSN has adapted to accommodate patient need, regardless of age. Recently, in order to enhance care delivery, other changes have been initiated in the field of chronic disease management and prescribing.

Legislation

The Medicines Act of 1968 states who can prescribe, and under what circumstances. For many years, DSNs have been working outside this law to accommodate the needs of the service. Most DSNs have locally agreed protocols for titrating insulin doses and oral hypoglycaemic agents. After their advent in 2000, many nurses working within diabetes used PGDs as an alternative to local protocols because, being authorised by the Drugs and Therapeutic Committee of the Trust, they appeared more formal (NHS Executive, 2000).

However, PGDs were never intended for the management of long-term conditions in individual patients. PGDs are instead written to enable registered nurses and other registered health professionals to supply and administer a specified medication to a *group* of service users who may not be individually identified before treatment (NHS Executive, 2000).

In the authors' opinion, however, there is little doubt that should those using PGDs at present stop using them, the DSN services across the UK would suffer severely.

The supplementary prescribing course and older people with diabetes

With the arrival of the supplementary prescribing course, there is now a legal basis for the DSN to alter treatment doses and to add in treatments if required. The course for independent and supplementary prescribing takes into account pharmacodynamics (effect of the drug on the body) and pharmacokinetics (effect of the body on the drug). Knowledge of pharmacodynamics enables the prescriber to predict drug action and likely side-effects, while pharmacokinetics (absorption, distribution, metabolism and excretion) will guide dosing and monitoring strategies. There is a range of conditions that will affect physiology and prescription choices – particularly in the older person:

- renal function declines with age; metabolism for some drugs is changed with age
- lean body mass means some older people will need smaller doses
- polypharmacy means drug interactions are more likely
- older people can also be more sensitive to some drugs and more prone to some side-effects (BMA and RPSGB, 2005; DoH, 2001a; DoH, 2005a).

This may be the first course where the nurse has had the opportunity to study the effect of drugs on older people in any depth. This could make his/her prescribing safer than it may have been prior to the course.

Following completion of the course, the nurse can prescribe from the *Nurse Prescribers' Formulary* as an independent prescriber or from the whole *British National Formulary* as an SP using a CMP.

A common need?

As health professionals, we have to question whether all DSNs need to be SPs in order to provide effective care for their patients. It may be argued that more important in caring for the older people with diabetes is the use of the core skills of nursing which have already been developed over the years – skills, such as communication, empathy, listening, counselling and motivating change, that nurses seem happy to now delegate to others as they undertake and achieve more qualifications. In the authors' opinion, these

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are real skills that are in danger of being eroded. Particularly with our older patients in mind, should we not be concentrating upon the skills that are in danger of being lost in the process of moving away from good nursing care?

However, the following decisions still need to be made:

- How many diabetes specialist nurses need to be able to prescribe in order to fulfil their role effectively?
- How many nurses would choose to take this on board if it was not being encouraged as 'the thing to do next'?
- How many nurses want to put themselves through another stressful course, where achieving the certificate will not be the end, since regular updates will be required to ensure competencies with new drugs?

For some, service development will cause difficulties, particularly for those in rural areas, where close access to their team is not comparable to inner city or secondary care teams. Until all centres have access to a complete electronic patient record system, there will be additional pressures – e.g. extra paperwork requirements and time constraints. For primary care colleagues, setting up CMPs with each GP may prove difficult.

There are also important considerations to ensure compliance with legalities: when the independent prescriber and SP reach an agreement about the limits of their responsibilities, communicating by telephone or fax may not be acceptable. Individuals should be aware that, should anything untoward happen, it may be impossible to prove that another professional actually received a fax or telephone call.

Safety and older people

What training and regulations (checks) are currently in place to ensure that nurse prescribing is safe and effective? The supplementary prescribing course itself is nationally recognised and registers an individual as a qualified prescriber on the Nursing and Midwifery Council (NMC) records (DoH, 2003). Furthermore, following successful completion of the course, a medical prescriber must be prepared to supervise and assess a nurse's prescribing. The employer confirms not only

that he or she will support the nurse's training, but in addition that they will support the nurse to gain access to continuing professional development (DoH, 2003).

Older people represent approximately half of the total number of people with diabetes, with many suffering from multiple disorders compared to the non-diabetic population (Dornan et al, 1992). Safety in prescribing is of particular concern with older people in order to avoid excessive, inappropriate or inadequate consumption of medicines DoH, 2001a), and to achieve patient satisfaction and compliance with care delivery (Pettersson et al, 1998).

An advantage of PGDs is that they always err on the side of caution; patient safety is paramount and strict usage criteria are set that are monitored regularly by others. In contrast, supplementary prescribing presents an opportunity for the SP to make judgements that may be outside of his/her scope of expertise and could prove damaging to the patient – although this is against the NMC's *Code of professional conduct* (NMC, 2002).

An example is the use of metformin. The value of this drug as part of a diabetes treatment plan is well appreciated. It would not be prescribed by a professional acting as SP for patients with renal disease, but what about a patient with heart failure as well as diabetes? The majority of DSNs have not been trained to assess a patient's degree of cardiac failure, so the nurse must make a judgement, or ask a more senior medical staff member. If the SP's judgement is wrong, a patient could become seriously ill or die. Alternatively, if SPs ask a more senior medical staff member, they are back to where they are today using PGDs rather than prescribing.

There is also an issue regarding inpatient care. To date, few DSNs have been involved in treatment titrations/changes for diabetes patients in the ward setting because of the 'can of worms' that would open. With the advent of supplementary prescribing, this situation changes markedly and could potentially pose many problems (even though a CMP may be in place), as inpatients' conditions change rapidly.

Resources

There is a variety of issues which still need further discussion to ensure all questions

have been answered. Those DSNs incorporating supplementary prescribing into their role will find that it will not affect their banding for Agenda for Change. However, it will cause increased pressure relating to competencies since supplementary prescribing will be assessed in addition to the competencies of the Knowledge and Skills Framework (DoH, 2004) and new job profiles for Agenda for Change (DoH, 2005b).

Furthermore, supplementary prescribing training is currently free, but it remains to be seen who will carry the cost in 2006 when funding for training will be required at a proposed cost of £1000–2000 per individual (DoH, 2002).

Finally, it will take approximately 3–5 years to facilitate the training of current DSNs with a supplementary prescribing course that will be evolving to accommodate need (authors' calculation based on a consideration of DSN numbers, available course vacancies, and current uptake of the course by DSNs in the northwest region). Therefore, how can standardisation of training across the country be ensured?

Conclusion

For nurse prescribing to succeed in any form, whether supplementary prescribing or PGDs, the multidisciplinary team must have clear objectives.

- There has to be full team acceptance of need and an understanding of what the implications will be.
- All medical staff working with DSNs need to be committed.
- DSNs need to consider the implications of potentially de-skilling junior medical staff and other nursing colleagues.

For DSNs to become supplementary prescribers and therefore prove what many say they are already doing, and have been doing for years, there are hurdles to overcome. However, to become an SP is to keep within the law and is an opportunity for many to learn more about prescribing.

It is the authors' belief that if DSNs do not grasp the opportunity to become SPs now they will not have any say in the navigation of nurse prescribing in the future. Having assessed among each team the appropriate way to move forward with nurse prescribing, let us, as DSNs, make this our opportunity to

make a real difference for all age groups treated by diabetes services as they tackle the challenges of the National Service Frameworks for older people and for diabetes (DoH, 2001b; DoH, 2001c). ■

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