

Nurse prescribing: The pros and cons



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Nurse prescribing was introduced nationally in 1998 as a result of the *Cumberlege Report* (Department of Health [DoH]; 1986) and the first *Crown Report* (DoH, 1989). The *Medicinal Products: Prescription by Nurses etc Act 1992* gave a legal framework to allow nurses to prescribe from a limited formulary – the Nurse Prescriber's Formulary. The scheme (labelled 'V100') was piloted in eight demonstration sites (set up in 1994; Morris, 1994). Initially, the course was only open to district nurses and health visitors. Practice nurses were not included in this group unless they had a health visiting or district nursing qualification.

The consultation document (DoH, 2000) announced the Government's intention to extend the nurse prescribing role, necessitating a longer course with increased pharmacology training, allowing the qualified prescriber to prescribe from the Nurse Prescribers' Extended Formulary. This was, again, a limited formulary designed mainly for minor illnesses and therefore not very useful in the management of long-term conditions.

The final *Crown Report* (DoH, 1999) recommended the setting up of two types of nurse prescriber, independent and supplementary. The independent prescriber can assess and diagnose. For the supplementary prescriber, a doctor assesses and diagnoses. Following this, a Clinical Management Plan (CMP) is drawn up, allowing the supplementary prescriber to prescribe from then on. The DoH (2005b) describes it as:

'a voluntary prescribing partnership between an independent prescriber and a supplementary prescriber, to implement an agreed patient-specific clinical management plan with the patient's agreement.'

The CMP appears in some cases to be a major obstacle to the commencement of nurse prescribing, except for those who are working closely with their independent prescribing mentor, such as diabetes specialist nurses (DSNs) with consultants or practice nurses with GPs. However, some DSNs are experiencing long delays when waiting for a 'blanket' CMP, for use with GPs in their district, to be approved. Added to this, contact with surgeries to confirm that records are up to date is time consuming.

The DoH (2006) gives a clear definition of independent prescribing as:

'prescribing by a practitioner (e.g. doctor, dentist) responsible and accountable for the assessment of patients, with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing.'

Supplementary prescribing is ideally suited to nurses caring for people with long-term conditions, such as specialist nurses and practice nurses, and is particularly beneficial in diabetes, as the Audit Commission (2000) found that 75% of diabetes care is delivered in primary care. Supplementary prescribing training (labelled 'V300') was introduced in 2002.

The latest Government document (DoH, 2006) – following consultation (DoH, 2005a) – sets out steps to implement independent prescribing in England for:

- registered nurses (1st level)
- registered specialist community public health nurses
- registered midwives
- registered pharmacists.

This is for all nurse prescribers who have completed the V300 course and came into force on 1 May this year. Nurses are able to prescribe from the whole formulary within their realms of competency, if approved by their employer. From the end of April 2006, the Nurse Prescribers' Extended Formulary ceased to exist.

The document states that a nurse independent prescriber (formerly an extended formulary nurse prescriber) 'must be a 1st level registered nurse [...] who has successfully completed an approved programme of preparation and training for nurse independent prescribing.'

The Nursing and Midwifery Council is discussing training and assessment at present. The document states that nurses who train as independent prescribers must have the ability to study at level 3 (degree level) and 'will be able to prescribe any licensed medicine [...] for any medical condition, including some Controlled Drugs'. They must only ever prescribe within their own level of experience and competence and must be assessed as 'being competent to take a history, undertake a clinical assessment and make a diagnosis.'

This will eliminate the need for CMPs, except when nurses are prescribing outside their area of clinical expertise, unless they can prove that they

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Table 1. Some of the advantages and difficulties with nurse prescribing experienced by nurses.**Advantages**

- The nurse's role is extended, giving job satisfaction and autonomy.
- It eliminates the requirement to advise GPs of a change of treatment.
- Aided by a Clinical Management Plan (which only needs updating annually), a supplementary prescriber can now formally titrate insulin and oral hypoglycaemic agents. Before this, the legality of titration was always a matter of some concern for diabetes specialist nurses (DSNs) and practice nurses.
- It eliminates the need to request a prescription for people with diabetes, although for many years the experienced DSNs and practice nurses have advised independent prescribers on treatment regimens.
- The initiative also provides continuing development of the nurse's role and supports service modernisation.
- It better utilises the skills of nurses.

Difficulties

The following are difficulties with nurse prescribing experienced by nurses:

- the time taken to train and the many hours spent in self-study
- staffing implications for the team from which the nurse is seconded (anecdotally, cover for this is very rarely provided)
- increased workload
- lack of access to complete medical records
- dissatisfaction among nurses who experience lengthy delays between becoming a qualified prescriber and the actual practice of prescribing. *Some have reported a time lag of up to 12 months while their name is officially entered on the register and they wait for their prescription pads. The time delay between qualifying and prescribing can result in a reluctance to prescribe without undertaking an update.*

also have the expertise or a recognised qualification in that area. However, if this were not the case, although they can legally prescribe, their employing trust would not cover them should any problems occur. They must be adequately insured. If they have completed the appropriate training and prescribe with their employer's consent, the employer becomes vicariously liable (DoH, 2005b).

The programme comprises 26 days at a higher education institute, as well as 12 days of 'learning in practice', when a designated medical practitioner will supervise and support the trainee and be responsible for assessing whether the trainee is competent.

Advantages and disadvantages

As things stand now, there are advantages and disadvantages of supplementary prescribing. Advantages for the service user include the following.

- The service user can be issued with a prescription immediately at the point of need, in the absence of an independent prescriber, whereas a GP surgery sometimes needs 24–48 hours' notice.
- It will exclude a further visit to the surgery for the service user.
- It increases continuity of care.
- It will be particularly beneficial for titration of oral hypoglycaemic agents and conversion to insulin.

Potential advantages and difficulties with nurse prescribing experienced by nurses are listed in *Table 1*.

The more cynical may say that nurse prescribing is a cheaper option and rids the independent prescriber of more routine prescribing, but as Dr Molly Courtenay and Nicola Carey say in the accompanying article (pages 97–100), there are some advantages for doctors, which include:

- reduced workload
- fewer interruptions to sign prescriptions (Avery et al, 2004)
- a means of refreshing diabetes knowledge.

Some doctors are supportive of the process but others are not happy. Dr Paul Miller of the British Medical Association (BMA) was reported as saying in a press release (BMA, 2005):

'This is an irresponsible and dangerous move. Patients will suffer. I would not have me or my family subject to anything other than the highest level of care and prescribing, which is that provided by a fully trained doctor.'

Dr Hamish Meldrum, also of the BMA, raises the issue that even some nurses ask about when discussing nurse prescribing:

'We are extremely concerned that the training provided is not remotely equivalent to the five or six years training every doctor has undertaken.'

This is a fair comment, but both clinicians seem to miss the point. Nurse independent prescribers 'must only ever prescribe within their own level of experience' (DoH, 2006). They must have been qualified for at least 3 years and practised in the area in which they wish to prescribe for at least 12 months, and the safety of the patient is paramount. The majority of doctors are confident in the competence of nurses involved in this process and more than happy to give them this independence.

As Dr Colin Kenny says in his commentary (page 96), nurse prescribing has generally been found to be appropriate, with few differences between doctor and nurse prescribing.

Conclusion

Nurse prescribing can present some difficulties for nurses, but the benefits appear to outweigh the pitfalls. It is an important development in diabetes care. Ultimately, the main consideration must be the service users. If nurse prescribing improves the quality of life and increases access for them, then we must be prepared to use it safely to its full potential. ■

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