Nurse prescribing in the acute setting: the future is here!

June James

Introduction

Diabetes nurse prescribing is in its infancy, with the first diabetes nurses qualifying in July 2003. The Department of Health (DoH) continues to demonstrate its enthusiasm for extended nurse prescribing and over 2000 nurses have undertaken appropriate nurse prescribing training, 1400 of whom are trained as supplementary prescribers (DoH, 2004). This article describes how the theory of nurse prescribing translates into diabetes practice in the acute care setting. The benefits of the process for people with diabetes, health professionals, and diabetes specialist nurses are discussed and consideration is given to its impact on diabetes nursing as a profession.

The process leading to diabetes nurse prescribing has evolved over many years: as a profession we have looked forward to the day when diabetes specialist nurses (DSNs) could access training and prescribe for people with diabetes (Watkinson, 2000). With the legislative framework now in place (Department of Health, 1999; DoH, 2000a), diabetes nurse prescribing has taken a giant step forward. DSNs now have access to the relevant training and the number of DSNs undertaking such training appears to be rapidly increasing. primary care trusts and acute trusts are actively encouraging DSNs to enroll on courses. Those qualifying can at last legitimately advise and prescribe for people with diabetes.

Prior to these new initiatives, DSNs traditionally advised both people with diabetes and health professionals regarding the types and dosage of diabetes medication, but this process was not legitimised. However, following registration with the Nursing and Midwifery Council, extended nurse prescribers can now legally prescribe from either the extended *Nurse Prescribers Formulary* (British Medical Association, 2002) as independent prescribers or from almost the entire *British National Formulary* through supplementary prescribing.

Supplementary prescribing

Despite recent additions, the extended *Nurse Prescribers Formulary* remains very restrictive for diabetes nursing, hence the majority of prescribing for DSNs will be through the supplementary pathway. This requires the agreement of a clinical management plan by a doctor/dentist (independent prescriber), the nurse (supplementary prescriber) and the patient (DoH, 2003a). It enables nurse prescribing for that individual for up to one year. The clinical management plan does not need to be drug or dose specific, and whilst it must indicate that agreement has been reached between all three parties, it does not state that signatures are required (DoH, 2003a).

Keeping this process simple makes implementation much smoother, especially for DSNs working in satellite areas who do not always have easy access to medical staff. Agreement can be obtained through telephone, fax or e-mail contact. Some DSNs are experiencing delays in implementation of clinical management plans because their employers are demanding approval of templates by medicines management committees. This is contrary to the DoH recommendation that the management plans are a partnership agreement by the independent prescriber, supplementary prescriber and the patient. It must be

ARTICLE POINTS

1. The number of DSNs undertaking extended nurse prescribing training is increasing.
2. Supplementary prescribing requires an independent prescriber (doctor/dentist), a supplementary prescriber (nurse) and the patient to agree on a clinical management plan.
3. Implementation requires structure, common sense, PCT and acute trust support and motivation from the DSN and diabetologist.
4. There is an increased sense of autonomy, responsibility and job satisfaction that can accompany nurse prescribing.

KEY WORDS

- Nurse prescribing
- Training
- Implementation
- Management plan
- Formulary

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PAGE POINTS

1 Only three clinical management templates are used and these do not need to be drug or dose specific. A reference copy and supporting information are retained for inspection.

2 Initially only insulin and oral hypoglycaemic agents were prescribed.

3 People with diabetes describe poor experiences of inpatient care, though they should expect and receive good quality consistent care (NSF for Diabetes).

recognised, however, that each organisation employing supplementary prescribers may feel the need to approve templates in order to ensure that nurses are prescribing within an acceptable framework.

Theory to practice in the hospital setting

It may be imagined that translating the guidelines around supplementary prescribing into the day-to-day work of a DSN would be difficult. As one of the first diabetes nurse prescribers, there was no fixed path to follow. Implementation involved structure, common sense, PCT and hospital trust support, personal motivation and enthusiasm from the diabetologist.

There were some formalities: proof of registration and a copy of the nurse prescriber's signature were required by the pharmacy staff. A stamp recording the name of the nurse prescriber and qualification was obtained for use on the prescription pad. Three clinical management plan (CMP) templates for diabetes care were formulated and then agreed by the DSN (supplementary prescriber) and the doctor (independent prescriber). The management plan templates agreed for people with:

- type 1 diabetes requiring insulin therapies
- type 2 diabetes, requiring oral hypoglycaemic agents leading to insulin therapies if clinically indicated
- pregnant women with diabetes or gestational diabetes requiring insulin.

The templates are frequently used in both the outpatient clinics and for inpatients. The processes for prescribing in the inpatient setting are shown in *Table 1* and those for the outpatient setting are shown in *Table 2*.

A copy of the agreed templates, along with supporting evidence such as local guidelines and relevant NICE guidelines, is kept in the diabetes nursing office. This is available for inspection by either health professionals in respect of clinical governance, or people with diabetes.

Due to perceived difficulties with implementation I preferred initially to use diabetes medications such as insulin therapies and oral hypoglycaemic agents in the clinical management plans. However, as confidence in the process has grown, other medication such as treatment for hyperlipidaemia has been added to the templates for type 1 and type 2 diabetes.

The benefits for people with diabetes admitted to hospital

People with diabetes frequently describe poor experiences of inpatient care, particularly in relation to:

- inappropriate amounts and timings of meals and timings of medication (Hiscock et al, 2001)
- inadequate knowledge of diabetes among hospital staff and lack of information provided (Audit Commission, 2000)
- discharge delays, even when diabetes was not the original reason for admission (DoH, 2002).

The aim of the *National Service Framework for Diabetes*, Standard 8 'Care of people with diabetes during admission to hospital' is: 'to ensure good quality

Table 1. Local implementation for inpatient care

- The patient's agreement is required
- The original CMP remains in the diabetes nursing notes
- Diabetologist and two other senior medical staff act as an independent prescriber for most inpatients with diabetes
- For pregnant women with diabetes, the obstetrician also acts as an independent prescriber
- Documentation for inpatients is included in nursing notes/medical notes

Table 2. Local implementation for outpatient clinics

- The patient's agreement is required
- Clinic doctors act as independent prescribers
- GPs receive the clinic summary and a copy of the CMP
- The original CMP remains in the diabetes nursing notes

consistent care is provided for people with diabetes whenever they are admitted to hospital' (DoH, 2001). The whole of this diabetes NSF is said to be underpinned with the philosophy of patient empowerment (Standard 3). However, when reviewing the person with diabetes' experience of inpatient care in the literature (Hiscock et al, 2001), it appears there is still much to be done. People with diabetes feel that control of their diabetes is often removed following admission to hospital. Insulin injections are frequently written up daily and people may have their insulin and meals delayed whist awaiting the prescribing instruction.

A recent six-month ward-based trial run locally, in which insulin was prescribed for inpatients over a three-month period, demonstrated the benefits for people being treated through the nurse prescribing process. Pre-trial data collected showed that with some inpatients insulin doses tended to be written up on a daily basis and by different members of the medical profession. Two of the patients reviewed had been prescribed insulin by nine different doctors over a three-week period and the insulin was only written up for short periods of time. This process inevitably led to delays in treatment and changes being implemented.

This trial supported the deficiencies in service delivery discussed by Hiscock et al (2001). Locally, diabetes nurse prescribing has benefited people with diabetes admitted to hospital and addressed some of the gaps in service that were identified by Hiscock et al (2001) and also in the ward trial, as shown in *Table 3*.

The benefits for ward-based health professionals

Inadequate knowledge of diabetes among hospital staff is highlighted in the Audit Commission report (2000). There is often little scope for formal diabetes training for ward-based staff. Areas relating to this problem are:

- a shortage on nurses working in the health service (Finlayson et al, 2002)
- the regular employment of agency and bank staff to support existing ward-based staff
- the requirement to meet government waiting times for surgery (DoH, 2003b)
- the reduction in junior doctors' working hours (DoH, 2003c).

Whilst structured diabetes education for health professionals is offered in many trusts, most ward staff find it difficult to attend for the above reasons. Nurse prescribing in the ward setting provided an additional opportunity for one-to-one updates on current therapies and treatments as each prescribing intervention was discussed with ward staff.

Areas where ward staff felt their knowledge had improved as a result of DSN insulin prescribing were as shown in *Table 4*.

Nurse prescribing for diabetes specialist nurses

On a personal level nurse prescribing is transforming my practice; I am able to fully complete the consultation process from assessment to treatment without needing to refer to a medical practitioner for prescription-only diabetes medication. The process offers equal opportunities for both discussion and care planning with each patient, doctor and nurse. Prescribing for the individual can then be continued through follow-up clinics. There is a sense of greater autonomy but linked with that is an increased sense of responsibility. Nurse prescribing has led to improved job satisfaction.

PAGE POINTS

1. There appears to be inadequate knowledge of diabetes among hospital staff.
2. Diabetes nurse prescribing can reduce delays in treatment initiation or dose changes.
3. Formal training for ward-based staff is limited due to pressure of work and irregular staffing.
4. Staff felt their knowledge had improved as a result of DSN presence and education.

PAGE POINTS

1 Some trusts are demanding that if nurses have not undertaken extended prescribing training, patient group directives must be used. This will not legalise DSNs prescribing in the latter cases.

2 Nurse prescribing is not for all: it should be a voluntary process for nurses but it can lead to greater sense of responsibility and job satisfaction.

Patient group directives (PGDs) and nurse prescribing

In some areas where staff currently advise on treatment and dose changes without the back up of either extended nurse prescribing training or PGDs, they are finding that clinical governance managers are insisting that one or the other process be initiated.

PGDs relate to the supply and administration of prescription-only medicines and, according to recommendations, should specify the medication and details of appropriate dosage, including maximum dosage (DoH, 2000b). Such tight specification may be of no use to DSNs who are well aware that often major changes in dosage need to be made, depending on the individuals' condition.

Vick and Gardner (2000) and Padmore (2000) recognised that PGDs would not legalise DSNs' practice in this respect. Padmore discussed the conflict confirming the DoH's stance that long-term therapy for chronic disease management is not expected to be covered by PGDs, but rather through supplementary prescribing.

Trusts demanding PGDs to legitimise all DSN advice regarding dose adjustment may need to consider whether non dose-specific directives or protocols will meet their own requirements. This may already be accepted in some trusts, according to Green (2004), who states that her trust considers that DSNs may not need to undertake extended nurse prescribing because 'they are apparently not **prescribing** a dose change, but simply adjusting a dose of insulin already prescribed by the doctor.' Green goes on to reiterate that this is confusing for all concerned!

Future implications of nurse prescribing in diabetes

How do these issues impact on diabetes nursing? Nurse prescribing in diabetes is not for all. Some DSNs are concerned that PCTs and acute trusts will pressurise staff to attend training. However, the guideline for implementation states: 'Nurses should not be nominated for training to extend prescribing if they do not want to prescribe' (DoH, 2003a). Some nurses do not want the increased responsibility that prescribing requires, and some are unhappy with the course length and the amount of study that needs to be undertaken (Green, 2004).

It may be argued will there be a two strand system of diabetes specialist nursing; one consisting of extended nurse prescribers and one with DSNs working according to PGD or protocol. If so, how will that affect career prospects? What about adequate recognition and remuneration for the increased responsibility?

John Reid, the Minister of State for Health, in his speech at the Chief Nursing Officer's Conference (DoH, 2003d) states that by 'opening the prescription pad to nurses, we have given them a powerful and symbolic tool' and that the process acknowledges that nursing is not subservient to medicine, but plays an equal part in health care. Despite DoH promises that nurses will

Table 3. Gaps in service identified and addressed

- Delays in treatment initiation or dose changes were reduced
- Ensured that insulin was prescribed both regularly and over a longer time-span
- The number of health professionals prescribing for the individual was reduced
- The patients were enabled to participate in the decision making process around medication
- The provision of information about diabetes medication including side-effects and contraindications

Table 4. Areas in which ward staff felt their knowledge had improved

- Insulin treatment and interpretation of blood glucose results
- The discontinuation of sliding-scale regimens and post sliding-scale treatment
- Insulin regimens, dose adjustment and interpretation of blood glucose results
- Knowledge of new pens and devices
- Better understanding of diabetes
- Drug interactions

be rewarded for additional responsibilities through 'Agenda for Change', there has been no indication that nurse prescribing skills will enhance either banding or payment. As job descriptions are evaluated prior to the introduction of 'Agenda for Change', all extended nurse prescribers would be wise to ensure that competencies and skills associated with this practice are included in their own job description.

These issues will continue to be debated and only time will bring the answers. If you have questions or concerns around nurse prescribing, it is vital that you share them either through the *Journal of Diabetes Nursing* Noticeboard or the nurse prescriber website forum (www.nurse prescriber.co.uk).

As DSNs we need to support each other in this time of change. One thing is certain: diabetes nurse prescribing is here to stay. It is good for people with diabetes, it provides an excellent basis for staff education and it promotes and enhances the skills of DSNs. ■

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PAGE POINT

1. DSNs should ensure that they include their prescribing skills and competencies in their own job description.

2. There is currently no indication tht prescribing skills will enhance either banding or payment.

3. Diabetes nurse prescribing is beneficial for people with diabetes, staff education and promotes and enhances the skills of DSNs