THE DEVELOPMENT OF NURSE PRESCRIBING: AN OVERVIEW

In 1986, recommendations were made for nurses to take on the role of prescribing. The Cumberlege Report *Neighbourhood Nursing: A Focus for Care* Department of Health and Social Security (DHSS, 1986) examined the care given to clients in their homes by district nurses (DNs) and health visitors (HVs). It was identified that some very complicated procedures had arisen around prescribing in the community and that nurses were wasting their time requesting prescriptions from the general practitioner (GP) for such items as wound dressings and ointments. The report suggested that patient care could be improved and resources used more effectively if community nurses were able to prescribe, as part of their everyday nursing practice, from a limited list of items and simple agents agreed by the DHSS.

Following the publication of this report, the recommendations for prescribing and its implications were examined. An advisory group was set up by the Department of Health (DoH) to examine nurse prescribing (Crown Report, DoH, 1989). Dr June Crown was the chair of this group. A number of recommendations were made involving the categories of items which nurses might prescribe, together with the circumstances under which they might be prescribed. It was recommended that:

> *'Suitably qualified nurses working in the community should be able, in clearly defined circumstances, to prescribe from a limited list of items and to adjust the timing and dosage of medicines within a set protocol.'* (DoH, 1989)

The Crown Report identified several groups of patients that would benefit from nurse prescribing. These patients included: patients with a catheter or a stoma, patients suffering with postoperative wounds and homeless families not registered with a GP. The Report also suggested that a number of other benefits would occur as a result of nurses adopting the role of prescriber. As well as improved patient care, this included improved use of both patients' and nurses' time and improved communication between team members arising as a result of a clarification of professional responsibilities (DoH, 1989).

An empirical study commissioned by the DoH and undertaken prior to nurse prescribing was carried out by Touche Ross (DoH, 1991). This work aimed to identify the benefits and costs of nurse prescribing. Research methods involved questionnaires and interviews. It was evident from this study that there was widespread support for the 'principles of nurse prescribing'. It was forecast that nurses, GPs and patients would experience small weekly time savings if nurse prescribing was introduced. Another anticipated benefit was speedier access to products.

During 1992, the primary legislation permitting nurses to prescribe a limited range of drugs was passed (*Medicinal Products: Prescription by Nurses etc. Act 1992*). The necessary amendments were made to this Act in 1994 and a revised list of products available to the nurse prescriber was published in the Nurse Prescribers' Formulary (NPF) (Box 1.1). During this period, guidelines were issued to the DoH from the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting (UKCC) and national boards with regard to the education that would be necessary to enable nurses to prescribe.

In 1994, eight demonstration sites were set up in England for nurse prescribing. Nurses working in these sites attended either the nurse-prescribing programme at the North East Surrey College of Technology or Manchester Metropolitan University, for the taught component of the nurse-prescribing programme (Mode 1 students).

Evaluation of pilot schemes has revealed a number of issues. A study by Luker *et al* (1997) identified from patient data that in some instances, patients chose to see a nurse as opposed to their GP. In some cases, the reason given for this was convenience. However, a number of patients

Box 1.1 – Items in the NPF English National Board (ENB, 1998)

- Laxatives
- Analgesics
- Local anaesthetics
- Drugs for the mouth
- Removal of ear wax
- Drugs for threadworm
- Drugs for scabies and head lice
- Skin preparations
- Disinfection and cleansing
- Wound management products
- Elastic hosiery
- Urinary catheters and appliances
- Stoma care products
- Appliances and reagents for diabetes
- Fertility and gynaecological products

considered nurses to have more expertise in certain clinical areas, e.g. wound care, and therefore sought their advice. It was also identified that, compared to the GP, nurses were found to be easier to talk to. Data collected from nurses illuminated that on the whole they enjoyed the experience of prescribing. There were both savings in time and increased job satisfaction. Nurses were also made more aware of the cost of items included in the NPF. Although anxieties were expressed about writing the first prescription, these anxieties disappeared once practitioners had settled in to their new role of prescriber. Some nurses in the study expressed concerns involving prescribing in conditions where a medical diagnosis was needed. This mainly involved laxatives, enemas and adult analgesia.

A further evaluation study (Blenkinsopp *et al*, 1998) involved the collection of data from nurse prescribers in two pilot sites (Walsall and Wigan). It was

found that although the nurse-prescribing training programme was generally well received, it needed to be strengthened in the areas of pharmacology, choice of preparation to be prescribed and financial aspects of prescribing. It was also recommended that the taught component of the programme would benefit from an increased focus on case studies in order to maximise the application of learning to practice. These findings were confirmed and expanded in the second part of this study (Blenkinsopp and Savage, 1999) which also identified that there is a need for nurse prescribers to have further information on the use of Prescription Analysis and Cost Trends (PACT) reports in the self-monitoring of performance.

An extension of the pilot prescribing scheme took place in 1996 at Bolton, prior to its national roll-out. Over 100 nurses participated. Following evaluation, prescribing was expanded to one community trust in each region of England and two in Scotland.

The funding for full national implementation of nurse prescribing was promised by the government in 1998 by former Health Secretary Frank Dobson at the Royal College of Nursing (RCN) conference in April. It is anticipated that by the year 2001, approximately 20,000 DNs and HVs will be qualified prescribers. Additionally, postregistration programmes for DNs and HVs now include the necessary educational component qualifying nurses to prescribe (Mode 2 students).

A report on the supply and administration of medicines under group protocols was published in 1998 (DoH, 1998) and a further report by Crown, which reviewed the prescribing, supply and administration of medicines, was published in 1999. This review recommended that prescribing authority should be extended to other groups of professionals with training and expertise in specialised areas. A possible example that was given by the report was family planning nurses. The review team recommended that application for prescribing authority should be submitted to an advisory committee – the New Prescribers Advisory Committee. The role of this committee would be to assess applications from 'independent' and 'dependent' prescribers. Independent prescribers would be responsible for the assessment of patients with undiagnosed conditions and make decisions regarding their clinical management and prescribing. A dependent prescriber would be responsible for the continuing care of patients previously clinically assessed by an independent prescriber. This might include prescribing. However, prescribing by dependent prescribers would be informed by clinical guidelines and might involve adjusting the dose of medication or repeat prescriptions.

The government decided to take forward the recommendations of the review of prescribing in March 2000, with a view to having new regulations in place by July 2000. Health Minister Philip Hunt said:

> *'At present, highly skilled nurses are prevented from prescribing for common conditions because prescribing has always been seen as the traditional role of the hospital doctor or GP.*
>
> *That in turn has meant that hospital doctors' time is being taken up with tasks that could and should be performed by nurses and other health professionals.'*

It was envisaged that independent prescribing authority would initially be granted to specialist nurses. Following evaluation, independent status would then be extended to include other health professionals.

At the time of publication of this book, the governments NHS Plan (DoH 2000) suggests that both the range of medicines that can be prescribed by nurses and the number of nurses with prescribing powers will be extended. However, further clarification is waited. Patient Group Directions (PGDs) (see Chapter 5) and their role is enabling nurses to supply and administer medicines according to protocols is also highlighted in this document.

EDUCATION AND TRAINING FOR NURSE PRESCRIBERS

A number of criteria laid down by the Medicinal Products: Prescription by Nurses Act 1992, and subordinate legislation under the Act, identify those individuals able to prescribe from the NPF. At the time of publication of this book, in order to prescribe, the nurse must fulfil all the following criteria.

- She/he must be a first-level registered nurse with a DN or HV qualification or the respective recordable qualifications at specialist practice level
- She/he must work within a primary healthcare setting
- She/he must have successfully completed the nurse prescribers' programme
- She/he must be identified by the UKCC as a nurse prescriber
- She/he must be authorised/required by their employer to prescribe.

The nurse-prescribing course (Mode 1 students) is a two-part integrated programme of education and training. It comprises:

- an open learning pack which consists of distance learning material and acts as a bridge leading from the learner's current experience into the taught component
- a 15-hour taught component, which builds on the knowledge provided in the open learning pack.

The pack is divided into a number of sections. The areas covered include the following.

- The history and development of nurse prescribing
- Accountability
- Prescribing safely and effectively
- Ethical issues
- Prescribing in a team context
- Administrative arrangements
- Evaluating effectiveness (ENB, 1998).

Each section of the pack comprises a number of learning outcomes, a list of suggested readings and a number of activities. Learners are required to assess themselves as they work through the material. Students registered on the programme are provided with the pack and usually given half a study day, which introduces them to the course, 4–6 weeks before the start of the taught component. It was initially suggested that the distance learning material would take 10–12 hours study time. However, evaluation has shown that 20–25 hours is a more realistic allocation of time (Blenkinsopp *et al*, 1998).

The taught component of the programme involves 15 hours of study and runs over a two-week period. During this element, the areas covered in the open learning pack are further developed. Students attend lectures on three days and are then formally assessed. The assessment covers material from the open learning pack and the taught component of the course. Short answer questions and multiple choice questions combined with case studies, which students are asked to discuss, are typical assessment methods used. On passing the exam, nurses become registered nurse prescribers and are able to prescribe from the NPF.

CONCLUSION

Although it has been recommended that further evaluation should take place regarding economical evidence, nurse prescribing has been considered a success by patients, nurses, doctors and other professionals (Luker *et al*, 1997). The development of nurse prescribing has been slow. It has been under consideration by the government since 1986 and to date, prescribing has only been extended to nurses holding a HV or DN qualification. It was not until March 2000 that the government decided to take forward the recommendations of the review of prescribing and extend prescribing rights to other nursing groups. However, clarification is still awaited.

Before the extension of nurse prescribing can take place, there needs to be a review of pre- and postregistration nurse education. Appropriate input from the life sciences, i.e. anatomy, physiology, pharmacology, needs to be included in nurse education programmes. If nurse prescribers are to be accountable for their prescribing decisions, they must be equipped with the knowledge and skills to inform them about patient diagnosis, illness and prescribing treatment. It is important that nurse prescribing contributes to improving patient care and that every effort is made to ensure that patient safety remains a priority.

Nurse prescribing should not be viewed as a means of dealing with increasing medical workloads, nor as a means by which doctors are able to delegate undervalued tasks to nurses. Therefore, training and educational needs must be met with the appropriate resources and funding. This will ensure that nurses feel secure in their prescribing role and confident that they are acting within their level of clinical competence.

Nurse prescribing will have a direct impact on the role of the nurse. It will enable nurses to adopt a more holistic approach to patient care and should promote cohesiveness within the primary healthcare team. Most importantly, the flexibility of nurse prescribing will enable patient care to become more tailored to the needs of the individual. However, as nurses increase their responsibilities in other areas of care and undertake activities that were once viewed as the domain of medical staff, some essential nursing activities will inevitably be delegated to unregistered staff. This will undoubtedly affect future professional relationships and boundaries.

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2

LEGAL AND PROFESSIONAL ACCOUNTABILITY FOR NURSE PRESCRIBING

THE LEGAL FRAMEWORK FOR NURSE PRESCRIBING

This chapter aims to explain the legal framework of nurse prescribing in order to increase awareness of and reflection on the legal background of nurse prescribing and the implications for personal accountability. Frequent reflection on practice is an implicit element in the United Kingdom Central Council (UKCC) *Scope of Professional Practice* (UKCC, 1992a). For nurse prescribers, this reflection will encompass all aspects of their new role and in particular their legal and professional duty of care for ensuring safe practice. This in turn requires the nurse to assess where potential breaches of duty may occur in prescribing and to take appropriate steps to minimise risks to patients. Failure to do so may make the nurse professionally and legally vulnerable in any allegation of negligence. Therefore, a basic knowledge of the law of negligence is essential for nurses prescribers practising in an increasingly litigious society. It is certainly the case that ignorance (of the law) is no defence.

The UKCC makes it clear that each nurse is personally accountable for actions taken and it is also evident that the law imposes the same standards

of care on those in a trainee or inexperienced capacity. This may include nurses taking on new roles such as prescribing. In ***Nettleship v Weston (1971)*** cited in Tingle and Cribb (1995), it was held that 'a learner driver would be liable in negligence if he failed to drive as well as a reasonably competent driver'.

This chapter examines:

- the background to nurse prescribing
- relevant legislation
- the law of negligence
- areas of potential breaches of care in prescribing.

THE BACKGROUND TO NURSE PRESCRIBING

Healthcare practice does not exist in a vacuum; it occurs within the legal frameworks created by society. Just as society itself is constantly changing, so too does the law in order to reflect the needs of society. Within this context, nursing developments may require the drafting of new legislation or the amendment of existing legislation to ensure that nursing practice is founded on sound professional principles within a legal framework. The implementation of nurse prescribing required new legislation in the form of the *Medicinal products: Prescription by Nurses etc Act 1992*. In addition, amendments to the *Medicines Act 1968* and the *Pharmaceutical Services Regulations 1994* were necessary before nurses could legally prescribe.

Amendments to existing legislation

The Medicines Act 1968 governs the prescription, supply and storage of medicines. Under this Act, it is unlawful for anyone other than an 'appropriate practitioner' to prescribe drugs. Doctors, dentists, veterinary surgeons and veterinary practitioners are the appropriate practitioners defined in the Act. Section 58 of this Act was amended to include 'registered nurses, midwives and health visitors' in the list of appropriate practitioners.

The *Pharmaceutical Services Regulations 1994* were also amended to allow pharmacists to dispense from prescriptions written by nurses.