USING SUPPLEMENTARY NURSE PRESCRIBING IN A MEMORY CLINIC

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This article describes the development of a nurse’s role in a memory clinic from that of doctors’ assistant to autonomous practitioner. It reports on a baseline audit of the nurse’s supplementary prescribing practice, which shows that most patients now receive prescriptions more quickly.

Memory services are recommended as the single point of referral for all suspected cases of dementia (NICE and Social Care Institute for Excellence, 2006).

The Bromley memory service is part of Oxleas NHS Foundation Trust in south-east London, which provides mental health and learning disability services. There are nearly 600 people on the memory service caseload, the majority of whom are prescribed cholinesterase inhibitors.

Patients attend the clinic for an initial assessment and those with Alzheimer’s disease are assessed to see if they are suitable for cholinesterase inhibitors. If patients are suitable they are initially prescribed a month of treatment and are followed up in clinic. Sometimes a patient cannot tolerate one of the drugs so they are tried on a different one. It can take several months before they are stabilised on an appropriate medication.

The clinics have a shared care protocol with local GPs.

LIMITATIONS OF THE CLINIC’S NURSING ROLE

The nurse’s role in the clinic was initially established as a doctors’ assistant who saw patients briefly before their appointment with the consultant and completed the Mini Mental State Examination with them. The nurse did not have time with patients or their carer to answer questions about their care and treatment.

I started working at the clinic in 2005 and, as a nurse with extensive experience in dementia care, I felt frustrated that I was not able to use my skills and expertise to the full. I analysed patients’ experience at the clinic and the way it was run to see if there were any changes I could make to improve services for patients and carers and also increase my job satisfaction.

In each of the consultant clinics there was an appointment stream for the consultant and another for their registrar. I proposed adding an additional stream to the clinic for patients to be reviewed by a nurse.

I approached one of the consultants with a view to conducting a trial of an additional nurse-led stream in his clinic. This would automatically increase the clinic’s capacity by 50%, enabling more patients to be seen.

Most of the new referrals to the older people’s community mental health teams are for people with memory problems. The clinics were often full, making it hard to find slots for urgent appointments. I suggested that I could see new patients for their initial assessment as there were pressures to meet waiting-list targets.

The consultants agreed and the nurse-led clinic stream was set up initially with one consultant. Within two months I had extended this service to all four consultants’ clinics, covering the whole of the memory service in Bromley.

PRESCRIPTION DELAYS

Despite the introduction of a nurse-led clinic stream, there was an ongoing problem with the supply of repeat prescriptions or prescriptions for new doses of cholinesterase inhibitors that were required between clinic appointments. Prescriptions may need to be changed depending on the patient’s response or any side-effects.

Patients or their carers had to telephone the clinic with prescription requests. My office is in the building where the clinics are held but only one of the consultants is also based here. This meant that it could be up to a week before the correct doctor was available to write the prescription. This led to unnecessary delays for patients or time spent contacting the appropriate consultant if a patient’s request was urgent.

Patients attending my clinic also experienced delays if they required a prescription as I had to liaise with a consultant about their treatment.

Using supplementary prescribing

I undertook a course in supplementary and independent prescribing at the University of Greenwich and have undertaken the role of supplementary prescriber for over a year.

I meet the consultants after each clinic to discuss new patients who have been
prescribed cholinesterase inhibitors. I follow up these patients in my clinic during the titration phase of their treatment. When I have assessed patients in my clinic stream, I can respond to their telephone calls for repeat prescriptions and prescribe in accordance with their clinical management plan. This is reassuring for service users and carers who are often worried about how they will obtain their prescription.

I explain to patients and their carers that I will contact the consultant if I have any concerns regarding their medication. Good communication between the supplementary and independent prescriber is an essential aspect of supplementary prescribing.

I also provide patients and carers with my contact number in case they have any questions or concerns after their appointment. This is well received and carers report feeling reassured by knowing there is someone they can telephone between appointments.

AUDIT OF PRESCRIBING PRACTICE
After the first nine months of prescribing, a baseline audit was carried out to identify patterns of non-medical prescribing and set a baseline for future clinical audit. The audit aimed to find out what impact nurse prescribing had made on the service.

I wanted to identify if patients who phoned for a new prescription received it earlier as a result of my prescribing role. This was calculated by counting from the date the prescription was written to the date the consultant would have been available in the clinic to deal with the request. The details of each prescription had been recorded in accordance with the trust’s non-medical prescribing policy.

RESULTS
I wrote 113 prescriptions in the first nine months of the nurse clinic stream.

Donepezil (Aricept) was the most frequently prescribed drug, accounting for 81 (72%) of all prescriptions. The main reason for prescribing was titration, which accounted for 87 (77%) prescriptions.

The audit looked at whether patients received their prescriptions earlier as a result of a nurse being able to prescribe. Out of 113, 18 (16%) patients were seen in clinic and received the prescription at their appointment. Twelve (11%) received it six days earlier and nine (8%) five days earlier. Before the introduction of supplementary prescribing, a consultant had to become involved in prescribing their treatment, which resulted in a delay in prescribing.

The most important finding was that 92 patients (81%) who contacted the nurse for their prescription received it earlier because the nurse was able to prescribe.

DISCUSSION
Gibson et al (2003), describing non-medical prescribing in paediatric settings, noted that in nurse-led clinics, nurses often see patients with whom they have established relationships over time and that this helps provide more complete care. The same is true in a memory clinic setting, as we can follow up patients over several years. I have developed relationships with my patients and their carers and this has enhanced their care. Bradley and Nolan (2006) suggested that nurse prescribing improves patient care and I am aware that having this additional skill has enabled me to complete the patient’s episode of care.

None of my patients or their carers have expressed any concerns about a nurse prescribing. Page et al (2007), in their study of a memory clinic, found that all service users and carers interviewed trusted the nurse prescriber’s competence.

As a result of the changes in my role at the clinic, I now work in a more autonomous way. This has resulted in increased job satisfaction as I have developed new skills and self-confidence as a practitioner.

Bradley and Nolan (2006), in interviews with trainee non-medical prescribers, reported that non-medical prescribing enhanced their development as autonomous professionals. Nurses working in memory clinic settings who are non-medical prescribers also report this effect (Smith and Hemmingway, 2005).