Is the profession prepared for nurse prescribing in hospitals?

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Although originally developed for primary care, nurse prescribing is being extended to hospitals. A range of developments has made it increasingly relevant to hospital-based nurses, and it should enable them to provide more effective care. However, nurses must be aware of a number of professional issues to ensure prescribing is extended for the benefit of patients rather than other professionals, and that it promotes holistic patient care.

Nurse prescribing is an exciting development that is increasing nurses’ ability to provide flexible patient care. Since the Cumberlege Report recommended that community nurses be allowed to prescribe from a limited list of products (Department of Health and Social Security, 1986), scope has grown. This has been driven by government policies such as *Making a Difference* (Department of Health, 1999a) and *The NHS Plan* (DoH, 2000a).

The original *Nurse Prescribers’ Formulary* contained a limited list of appliances, dressings and 12 prescription-only medicines (POMs). In 2002 the *Nurse Prescribers’ Extended Formulary* was introduced to include all licensed pharmacy and general sales list (GSL) medicines (excluding controlled drugs) and about 140 POMs. To date 2,400 nurses have gained the additional qualification needed to prescribe from this formulary (DoH, 2004a).

In addition to expanding the range of drugs nurses can prescribe, the DoH has extended nurse prescribing to hospitals. It has proposed adding conditions focusing on emergency care to make it more relevant (DoH, 2004b; Box 1). A decision is expected shortly. Other developments extend nurses’ ability to prescribe a wider range of drugs in partnership with medical colleagues. These changes should improve care and cut delays in starting treatment.

This article focuses on the evolution of prescribing and supply of medicines in hospitals. Ward-based nurse prescribing is the logical progression after its success in primary care. Although most literature on nurse prescribing relates to primary care it has much to teach us about its application in hospitals.

**Implementation of nurse prescribing**

Although well established, implementation of nurse prescribing has been disjointed and often confusing. As a result, many nurses, patients and other practitioners may be unclear about the different routes via which nurses can supply medicines. The Crown II report (DoH, 1999b) recommended two categories of prescriber – independent and supplementary.

There are also mechanisms through which nurses can supply medicines without actually prescribing them or waiting for a doctor’s prescription.

**Independent prescribers**

Independent prescribers are responsible for initial diagnosis and assessment of patients, after which they prescribe the appropriate treatment. In addition to doctors and dentists, independent prescribers can be appropriately qualified nurses, midwives and health visitors, who can prescribe from the original or the extended formulary.

**Supplementary prescribers**

Previously known as dependent prescribing, supplementary prescribing is a partnership between an independent prescriber and a supplementary prescriber to implement an agreed, patient-specific clinical management plan (CMP) with the patient’s agreement. There are no legal restrictions on the conditions that may be treated or on the drugs, providing they can be prescribed at NHS expense and are referred to in the CMP. The DoH (2004b) expects it will usually be used in chronic conditions and health needs. About 1,700 nurses are qualified for supplementary prescribing, which is now included in training for extended formulary prescribing.

**Patient group directions**

Patient group directions (PGDs) evolved to enable non-medical professionals to supply medicines without direct reference to a doctor each time. PGDs are written instructions on the supply/administration of medicines to groups of patients with a particular condition. They are drawn up by a multidisciplinary team, including a doctor, a pharmacist and a member of the profession expected to supply medicines under the PGD. Working within the structure of the PGD, named nurses, who must be appropriately qualified and experienced, can supply medicines to patients within the doses stated in the PGD unless the patient requires referral to a doctor.

**Patient-specific directions**

A patient-specific direction is a written instruction from an independent prescriber for a medicine or appliance to be supplied or administered to a named patient. Situations in which they are used include instructions in patient notes in primary care, or on a hospital patient’s ward drug chart. If a patient-specific direction exists, there is no need for a PGD or clinical management plan.
BOX 1. PROPOSED ADDITIONS TO THE EXTENDED FORMULARY (DoH, 2004b)

CENTRAL NERVOUS SYSTEM
- Emergency treatment of meningitis
- Nausea and vomiting
- Prophylaxis and treatment of nausea and vomiting in the postoperative period
- Status epilepticus

CIRCULATORY
- Acute pulmonary oedema associated with cardiac failure
- Angina pectoris
- Fluid replacement and potassium replacement (hypovolaemia and dehydration)
- Plasma substitutes for patients with a low blood volume
- Thromboprophylaxis
- Ventricular fibrillation or pulseless ventricular tachycardia

OPHTHALMIC CONDITIONS
- Diagnostic use in ophthalmology, tear deficiency, inflammation following ophthalmic surgery, corneal trauma

GASTROINTESTINAL CONDITIONS
- Prophylaxis of acid aspiration during surgery

INFECTIONS
- Cellulitis (ascending cellulitis of the leg, rather than inflammation associated with varicose ulcers)

MUSCULOSKELETAL
- Acute dystonias
- Acute severe pain after trauma
- Changing painful dressings
- Pain and inflammation/soft tissue injury

ORAL CONDITIONS
- Dental infections

POISONING
- Poisoning
- Tetanus treatment

RESPIRATORY
- Acute exacerbation of chronic bronchitis
- Acute reversible airways obstruction (acute severe asthma or acute exacerbation of chronic obstructive pulmonary disease)
- Anaphylaxis
- Conditions requiring oxygen supplementation (for example hypoxaemia)

SKIN
- Psoriasis
- Molluscum contagiosum

SUBSTANCE DEPENDENCE
- Acute alcohol withdrawal
curriculums, this will necessarily be at the expense of other subjects. This may have a negative impact on the holistic model and definition of nursing.

Some believe the government is backing nurse prescribing simply to resolve the chronic shortage of medical staff. Shepherd (1999) describes nurses as being manipulated into extended roles to fill the gaps left by medicine. However, the government may have realised that the NHS has not been fully utilising nurses’ abilities.

Some nurses may fear that prescribing is another step towards the medicalisation of the profession, diverting attention from basic patient care. It is true that the process of diagnosis and prescription involves signs, symptoms, pathology, prognosis and the course of disease – all of which are integral to the medical model.

Nursing has always complemented medicine by concentrating on the effects of illness on patients’ physical, psychological and social well-being. The profession needs to consider whether extending nurse prescribing will result in a loss of identity. If it becomes central to hospital care, more nursing activities will be delegated to unregistered support staff. However, nurses are already acting in developed roles, and prescribing may be seen as a logical extension of that, and some nurses may feel a more medical approach to patient care best suits their practice. It may be that we need to create a new professional role – and even a new title to reflect this change – for those nurses who are combining the medical model with holistic treatment. This role could include:

- Assessing patients and administering emergency treatments to agreed protocols;
- Communicating with patients and relatives;
- Ordering and undertaking diagnostic tests;
- Giving first doses of antibiotics and other drugs.

Another area that may threaten holistic treatment is the development of ICPs and PGDs. While these are evidence based and provide some degree of autonomy for nurses, they make it easy to lose sight of holistic treatment when developing them. Unless nurses pay attention to this, they may again drift toward a medical model denying their aesthetic nursing skills.

Conclusion
There are many ways in which nurses may influence the development of nurse prescribing in hospitals. Ideally, it will be extended primarily to enable nurses to provide timely, evidence-based medication in any setting to improve patient outcomes and quality of life. However, we must ensure that it is another tool enabling nurses to provide holistic, patient-centred care rather than simply to take on tasks delegated to them for the convenience of the medical profession.

Nurse prescribing could be another job given to an overworked and undervalued profession in the guise of increased professionalism and role expansion or it could lead to a more highly valued, educated and skilled profession. All nurses must recognise the changes taking place in our role and the nature of our profession, and consider how we want these to develop.

REFERENCES

This article has been double-blind peer-reviewed.
For related articles on this subject and links to relevant websites see www.nursingtimes.net
Nurse prescribing in hospitals

Although it is some time since proposals to extend nurse prescribing into hospital settings were published (DoH, 2000b), it is doubtful that significant numbers of hospital-based nurses have qualified as independent prescribers, apart from some specialist nurses. However, clear benefits exist (DoH, 1989), including:

- Improvements to patient care;
- Better use of nurses’, patients’ and doctors’ time;
- Cost savings;
- Transfer of routine medical work to nurses;
- Challenging the professional power of doctors.

Although the above arguments related to primary care, they could equally apply to prescribing and the use of PGDs and patient-specific directions in hospitals. Most hospital nurses administer far more medicines than their colleagues in the community.

Hospital-based nurses spend a significant proportion of their time administering, reviewing and explaining medication to patients, colleagues, nursing students and even to junior doctors. In addition, experienced nurses often request prescriptions, indicating what they require and why, and the dosage needed for a given patient, and the doctor will often comply without examining the patient.

In such situations, medical prescribing is effectively a ‘rubber stamp’ giving legal authority to the nurse’s verbal prescription, in which the doctor’s accountability is entrusted to the nurse. If the nurse’s diagnosis is incorrect, the doctor is still legally accountable for the prescription. If hospital doctors are prepared to place this level of trust in nurses, surely appropriately qualified nurses can be trusted to prescribe medication themselves, and to take full accountability for their actions.

Bowman and Walton (1996) demonstrated nurses’ ability to prescribe in a study at a dermatology unit, which compared prescription decisions of nurses and senior house officers (SHOs) with those of consultants. Only 61 per cent of SHOs’ prescriptions were of the same type and potency as consultants’, while nurses accurately prescribed 80 per cent of the treatments.

Patients’ views

In any discussion about nurse prescribing it is important to consider the patient’s perspective, and whether they are comfortable with nurses prescribing their medications. Luker et al (1997), in a study of patients’ perceptions of prescribing in primary care, found that patients considered nurses to have sufficient knowledge to prescribe and in some cases felt they were better placed to prescribe items where they had in-depth knowledge.

It seems likely that hospital patients’ reactions to NP would be more subtle because the absence of a prescription pad would make it less noticeable to them. What they would notice, however, is that they received treatment more quickly. This support for nurse prescribing was confirmed by Luker et al (1998), who found 46 per cent of patients felt nurse prescribing resulted in better use of nurses’ and doctors’ time.

Nurses’ views

The other group whose perspective is important is nurses themselves – will they want to prescribe? Prescribing increases nurses’ autonomy and can enhance their ability to manage their time and make care delivery more efficient, and is likely to be welcomed by many. However, others will not want to prescribe or may not feel competent to do so. It is vital that implementation in hospitals is tailored to patients’ needs, using staff with the appropriate skills and motivation, and who are able to take the legal responsibility for prescriptions they issue (Cresswell, 1998).

Ensuring safety and effectiveness

One of the changes taking place in the NHS is a gradual shift in the power base towards nursing. As extended roles give nurses primary responsibility for an increasing number of patients. This should give nurses a strong influence on the future development of nurse prescribing. Its benefits in primary care should demonstrate the potential to improve patient care in more areas.

In order to ensure it is safe, effective and of real benefit to patients and the NHS, nurse prescribing should be introduced within a framework of clinical governance, so that it can be evaluated on an ongoing basis. Individual nurses must also continually monitor and reflect on their own practice. Clinical supervision offers the benefit of peer support. Nurse prescribers are required to undertake annual supervision, and trusts must hold a database of their prescribers and demonstrate that they actively offer clinical supervision sessions. These are led by a senior nurse and address national and local policy, continuing professional development and evidence-based practice, while facilitating reflection on practice.

Nurse prescribers need access to continuing evidence-based and quality assured training and development in order to maintain safe, high-quality and cost-effective prescribing practice. The National Prescribing Centre (NPC) provides a range of information and support to nurse prescribers and their managers, helping nurses to identify learning needs and serving as a tool for managers to commission services. The centre advocates the use of ‘cascade training’ and provides ongoing training and support to those who deliver this to prescribers at a trust level, as well as nurse trainers teaching nurse prescribers. Other organisations also provide opportunities for nurse prescribers to extend their knowledge and skills.

Professional issues

Prescribing is changing fundamental aspects of nursing, and while this may be largely beneficial, it will have knock-on effects on care provision. Ongoing needs to be aware of the changes already occurring, and those that may occur in the future, and to debate whether they are truly beneficial to the profession and to patients.

Preregistration programmes are likely to incorporate more pharmacology in their curriculums, as prescribing becomes increasingly central to nurses’ roles. However, with so many competing priorities in preregistration