Power to prescribe

NANCY LOVERIDGE discusses how nurse prescribing can affect autonomous care, and explores the associated issues of accountability and ethics.

The introduction of nurse prescribing has been called a ‘momentous role development’ (Larsen 2004), and one that undoubtedly will enhance the autonomy of emergency nurse practitioners (ENPs). Having experienced nurse prescribing in an A&E care setting, I share Wingfield’s (2005) belief that nurse prescribing is not simply a right but a professional responsibility. Chamberlain-Webber (2004) identifies succinctly the two forms of nurse prescriber as independent and supplementary, and describes the extra facility of patient group directions (PGDs), which enables non-prescribing nurses to supply and administer medicines (Box 1).

CONDUCT

The Nursing and Midwifery Council’s Code of Professional Conduct (NMC 2002) provides the basis for this advancement of practice by helping to safeguard patients and employers, as well as individual nurses and the nursing profession itself.

Many of the code’s clauses apply to nurse prescribing but the two that hold special significance are:

> 1.3. You are personally accountable for your own practice. This means that you are answerable for your own actions and omissions, regardless of advice or directions from another professional

> 6.2. To practise competently you must possess the knowledge, skills and abilities required for lawful, safe and effective practice without direct supervision. You must acknowledge the limits of your professional competence and only undertake practice and responsibilities for those activities in which you are competent’.

The code clearly states the need for nurse prescribers to be accountable for their actions; in other words, to justify their actions.

As Box 1 makes clear, if independent prescribers prescribe outside the boundaries of the extended formulary, they can be outside the legal framework for prescribing in the Code of Professional Conduct and the Guidelines for the Administration of Medicines (NMC 2004).

This situation has encouraged calls from many quarters, including emergency care consultant nurses, for all of the British National Formulary to be made open for independent nurse prescribers and I am sure that, in time, the range of drugs that can be prescribed will expand radically.

As generally assumed that, should their prescribing rights expand in this way, nurses would naturally be limited by the Code of Professional Conduct, it could also be argued that, given such greater licence to prescribe, some nurses would push

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<th>Box 1. Terminology</th>
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<td><strong>Independent prescribing</strong></td>
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<td>&gt; Nurse prescribers prescribe appropriate medication based on clinical assessment and diagnosis</td>
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<td>&gt; There are two types of independent prescriber: health visitors or district nurses, and nurse practitioners who prescribe from the nurse prescriber extended formulary (NPEF). In emergency care, this relates to ENPs or consultant nurses in A&amp;E departments or minor injury units (MIUs)</td>
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<td>&gt; The NPEF is found near the back of the British National Formulary. It covers nearly 80 clinical conditions and describes more than 180 related prescription-only medicines</td>
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<td>&gt; Prescribing rights also extend to general sales list medication, but these must be licensed to treat the conditions listed in the NPEF</td>
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| **Supplementary prescribing** |
| > Supplementary prescribing relates to a three-way partnership between the medical independent prescriber (doctor), the supplementary prescriber (nurse or pharmacist) and the patient |
| > Clinical management plans are drawn up between the three so that the supplementary prescribers can access a full enough formulary to manage long term conditions and any related acute exacerbations |
| > The only exception concerns controlled drugs and unlicensed drugs used outside formal clinical trials |
| > Supplementary prescribing rarely occurs in A&E departments or MIUs |

| **Patient group directions** |
| > Extensively used in the A&E and MIU settings, these allow the supply and administration of specific medicines to specific groups of patients |
| > Clear boundaries of practice relate to indications for and exceptions from administration |
| > Patient group directions are based on generalised directions of the doctor and are often heavily supported by local pharmacies |
| > Competency framework guidance can be found on www.npc.co.uk |

(Chamberlain-Webber 2004)
the boundaries too far, and not in their patients’ best interests.

As such, Clause 6.2 identifies a need to provide evidence of competency assurance. In terms of prescribing, this is shown in the first instance by nurses successfully completing extended or supplementary nurse prescribing courses, with the additional support of advanced practice qualifications.

EDUCATION

The extended nurse prescribing course is intensive, involving 26 days of university directed education and 12 days of clinical supervision. However, successful completion and qualification does not grant a mandate to prescribe any drug for any patient. This may be problematic in A&E or minor injury units (MIUs).

The supplementary nurse prescribing element of the course underpins supplementary prescribing, in which a wide range of drugs can be prescribed, albeit not usually in A&E.

Instead, it is the extended formulary for independent prescribing that provides the A&E and MIU nurses’ prescribing rights.

I personally acknowledge the value of the prescribing course, which has enhanced my knowledge of pharmacology and pharmacokinetics pertaining to all the drugs I use, including those covered by PGDs.

At present, PGDs provide the bedrock on which treatment regimes in A&E and MIU settings rest and, although I have a prescribing qualification, I for one shall continue to rely on this mode of drug administration for the near future.

SAFE PRACTICE

I believe completion of the course allows greater understanding in relation to the actions of drugs, and the implications of using different medication. This will lead to a safer, better informed approach to managing patients with drug therapies and reduce the number of patients experiencing unnecessary side effects.

Maintaining an up-to-date and expanding knowledge base of drug therapies is further implied in the Code of Professional Conduct in that practice must ensure that risk and error are kept to a minimum.

ACCOUNTABILITY

Accountability is not a simple issue. It requires an awareness of the drugs that independent prescribers can prescribe from the extended formulary – not always the drug of choice – and, of course, the clinical conditions in which they can be used.

Accountability also relates to safe and competent assessment, and identifying clinical history, allergies, current medication, diagnosis, treatment regimes and education about self-care and medication.

Such assessments often have to be made with unknown patients in consultations lasting only around 15 minutes. The ramifications of getting them wrong are profound; after all, none of us want to make errors of judgment that harm our patients.

The ethics of accountability in nurse prescribing are explored by Beauchamp and Childress (1994), and give rise to their principles of beneficence and non-maleficence, which relate to doing good and doing no harm respectively.

RESPONSIBILITIES

The call for lifelong learning and the reduction of clinical risk are the fundamental responsibilities of the privilege to prescribe. At my trust, these are achieved through the following initiatives:

- Frequent drug updates from the local pharmacy
- Allocating time for clinical reflection about prescribing scenarios
- Developing evidenced based clinical guidelines for common conditions
- Raising awareness about drug information in the nursing press
- Using the Department of Health website dedicated to prescribing issues.

Furthermore, it is important that nurses involve patients in their decisions about care delivery. This is stipulated in the Code of Professional Conduct and relates to the principle of autonomy.

A patient assessment I recently undertook offers an example. The patient displayed early signs of wound infection, with which the immune system was coping. The patient told me that he had had two courses of antibiotics already and did not want a third.

After discussion, we decided to take a wound swab to assess culture and sensitivity, clean the wound thoroughly, apply a medicated dressing and review in 48 hours. Within this period of time, the wound no longer appeared infected and was healing well.

By using therapeutic nurse-patient relationship, not only had the patient’s autonomy been upheld, but a package of care had been achieved consistent with Beauchamp and Childress’s principles of beneficence and non-maleficence.

CONCLUSION

Autonomous practice will undoubtedly advance with independent prescribing in A&E and MIU settings.

The extended formulary does not provide all the answers to the prescribing problems in this acute sector however and, as a result, nurses continue to rely on PGDs.

Nevertheless, we are developing an increasingly advanced autonomous practice supported by the responsibility of independent prescribing.

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References


