Nurse prescribing: what do patients think?


Abstract

Aim To explore nurse prescribing from the patient’s viewpoint.
Method This study was undertaken in one primary care group in Leicestershire. All prescribing health visitors (n=17), district nurses (n=9) and practice nurses (n=1) were asked to recruit five patients for whom they had prescribed. Fifty patients took part in a telephone or face-to-face interview. Participants were predominantly low or new users of nurse prescribing, while the nurse prescribers were experienced.
Results Participants identified that nurse prescribers had key skills in assessment, observation, diagnosing and providing information. Nurse prescribing was accepted by all participants as a practical and responsive method of service delivery. Gains identified were better use of the nurse’s and doctor’s time, convenience, a quality relationship with the nurse and expertise of the nurse. Disadvantages identified included the limitations of the Nurse Prescribers’ Formulary and the training and competence of nurse prescribers.
Conclusion This study helps affirm that nurse prescribers meet the needs of patients, with positive experiences in terms of the process and outcomes. Future developments suggested by participants appear to reflect government concerns. Such changes include the need to develop and maintain competence to uphold public safety and for the formulary to be expanded. To ensure that the NHS workforce is used more effectively, participants agreed with providing patient-centred services and the renegotiation of traditional roles.

Key words

- Patients: attitudes and perceptions
- Prescribing

These key words are based on subject headings from the British Nursing Index. This article has been subject to double-blind review.

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A time saving to the GP was identified. Patients no longer had to make appointments to see the GP about what they perceived as relatively minor or trivial things. This raises the issue of the extent to which patients had under-reported symptoms prior to nurse prescribing. Another time saving identified was to the benefit of the patient as the nurse could prescribe the item quicker, which meant that treatment could be initiated sooner.

Nurse prescribers were viewed as more approachable and spent a greater amount of time in consultation. Satisfaction was found with this consultation process because nurses ‘spoke the same language’ as the patients and used less medical jargon. Nurse consultations were also more relaxed, which might be explained by the fact that prescribing often occurred within patients’ homes rather than at GP practices. Thirteen per cent of the patients reported that nurses provided them with better information than the GP. This satisfaction was also increased by the fact that nurses were perceived as being more aware of patients’ personal circumstances – a patient-centred, holistic approach.

Patients also preferred the convenience of nurse prescribing. They did not have to make an appointment to see the GP, which particularly for non-urgent conditions could take anything from several days to weeks. Health visitors, in particular, provided drop-in clinics as well as visiting mothers at home, which helped relieve the burden for mothers getting to and from the GP surgery.

Very few patients identified disadvantages to nurse prescribing. Some patients were confused about what nurses were able to prescribe. However, Luker et al (1997a) reported that patients quickly became familiar with what nurses could prescribe and were clear about the professional boundaries between the nurse and GP. Patients who required medication on prescription, as well as items from the nurses’ formulary, identified a further disadvantage. Previously, both medical and nursing items had been contained in one prescription, whereas under the new system of prescribing, GPs and nurses prescribed separately. Under the previous system some nurses had delivered all the items that had been prescribed by the GP, whereas the onus in some instances was now on the patient to obtain the medication prescribed by the GP.

The aim of the study

The aim of this study was to identify patients’ experience of nurse prescribing to contribute to nursing science and practice. The main issues explored were:

- What were the patients’ reactions to or experiences of nurse prescribing?
- How acceptable was this current practice?
- Were there any patient gains, such as reducing under-reporting of minor symptoms, increasing compliance with treatment, knowledge gains, a more patient-centred, holistic approach?
- What were the disadvantages or inconveniences?

Method

A descriptive qualitative design was chosen for the study, as this design lends itself to the discovery of new facts about a situation, people, activities, events or the frequency with which they occur (Leninger 1985, Brink and Wood 1991). Interviews were used as the method of data collection; these were conducted either face-to-face in the participant’s home or via the telephone over a five-month period according to the participant’s preference. Interviews were organised at the patient’s convenience and provided an opportunity for a prepared explanation of the research, so explanations could be adapted to each patient’s level of understanding, which might have contributed to the high participation levels (Oppenheim 1992).

The interviews were primarily qualitative in nature and were analysed via content theme analysis (Burnard 1991), a form of content analysis in which raw data from initial categories were grouped to form mutually exclusive categories. Descriptive statistics were used to identify the size of the responses. The questions were analysed and themes identified independently and categories compared for consistency. The authors then compared themes and consensus was achieved.

Ethics The project was registered with Leicestershire & Rutland Healthcare NHS Trust R&D Committee, with ethical approval from De Montfort University and the Leicestershire Area
recruited in their study were high users of nursing services, which might have limited its generalisations. The fact that this study has discovered similar findings with a different type of service user (68 per cent of the participants were covered similar findings with a different type of generalisation.

The findings from this study confirm much of the speculation about the benefits of nurse prescribing identified in the Crown Report (DoH 1989). They also confirm some of the results of the evaluation project of 1994 (Luker et al 1997a). Luker et al (1998) acknowledged that patients who were selected in their study were high users of nursing services, which might have limited its generalisations. The fact that this study has discovered similar findings with a different type of service user (68 per cent of the participants were classified as low or new users with 1-3 prescriptions) serves two purposes. It validates Luker’s earlier findings and also the continued benefits of nurse prescribing as it has been rolled out across England.

Experience of nurse prescribing As the participants began to share their experiences and opinions during the interviews, similar responses began to emerge to the questions asked.

At the start of the interview, participants were asked to relay their experiences of nurse prescribing. Experiences ranged from mothers who had had babies before and after nurse prescribing and could make comparison between two different systems, to those for whom it was often their first experience of nursing in the community. The common themes that arose were the most common treatments identified. Some of the participants also made reference to whether the treatment prescribed was actually successful. Of these, seven (14 per cent) made a comparison with the prescribing practices of the GP identifying that what GPs had prescribed had been unsuccessful. For example:

<table>
<thead>
<tr>
<th>Box 1. Common themes identified from the questionnaires</th>
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<tbody>
<tr>
<td>Could you please share with me your experience/s of nurse prescribing?</td>
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<tr>
<td>- The number of prescriptions</td>
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<td>- Who wrote the prescription</td>
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<td>- Why the prescription was given</td>
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<td>- The outcome of the prescription</td>
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<td>- Comparison with prescriptions written by doctors</td>
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<td>- Key words used: assessing, observation skills, diagnosis and providing information</td>
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<tr>
<th>How do you feel about nurses prescribing?</th>
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<tr>
<td>- Surprise/not realising that the nurse could prescribe</td>
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<td>- It’s a good idea</td>
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<td>- Nurses should be limited to minor things</td>
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<td>- Need for nurses to be competent</td>
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<td>- Challenging the tradition of doctors-only prescribing</td>
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<td>- More timely and convenient system</td>
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<tr>
<th>Do you feel there were any gains/benefits to you as a result of the nurse being able to prescribe?</th>
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<tbody>
<tr>
<td>- Better use of doctors’ and nurses’ time</td>
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<tr>
<td>- Nurse aware of professional limitations/ liaison</td>
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<td>- Nurse as an expert</td>
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<td>- Timeliness – commencing treatment sooner</td>
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<td>- Convenience</td>
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<td>- Practicalities/cost implications</td>
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<tr>
<td>- Quality relationship (continuity, approachable, information/health promotion, reassurance and reducing under-reporting of minor symptoms)</td>
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<td>- Success of the treatment</td>
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<th>Do you feel there were any disadvantages/inconveniences to you as a result of the nurse being able to prescribe?</th>
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<tr>
<td>- Training and competency of nurse prescribers</td>
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<tr>
<td>- Limitations of the Nurse Prescribers’ Formulary</td>
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<td>- Faith in the current system</td>
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Results

Box 1 indicates the common themes identified from the questionnaires.

Discussion

The findings from this study confirm much of the speculation about the benefits of nurse prescribing identified in the Crown Report (DoH 1989). They also confirm some of the results of the evaluation project of 1994 (Luker et al 1997a). Luker et al (1998) acknowledged that patients who were selected in their study were high users of nursing services, which might have limited its generalisations. The fact that this study has discovered similar findings with a different type of service user (68 per cent of the participants were classified as low or new users with 1-3 prescriptions) serves two purposes. It validates Luker’s earlier findings and also the continued benefits of nurse prescribing as it has been rolled out across England.
public confidence. and expertise of the nurse prescriber as well as the patient’s and the government’s agendas, the If competence and education are high on both continuing professional development programme, but also a robust additional preparation process, but also a robust national preparation process, but also a robust education paper on nurse prescribing (DoH 2000a) was concerned with this very issue. The consultation reflected some of the key components of the advanced nurse practitioner (Carrino and Garfield 1995) whose judgements and skills are applied according to patient/client need.

**Feelings about the nurse prescribing** The participants were asked how they felt about nurse prescribing. They all agreed that it was a good idea, however, the majority expressed surprise that nurses were able to prescribe. Anderson (1999) acknowledged this lack of awareness. In this study, the patients who knew of nurse prescribing did so either because they worked in the health service or because a family member or friend had experienced the service. Only two patients had been told that their nurse could prescribe, by health visitors who had talked about this at mother and baby and at post-natal groups. Two participants had not actually realised that the nurse had prescribed for them. This finding was a surprise. After the long battle to implement nurse prescribing one would have assumed that nurses who are now able to prescribe would actively market their services. However, promoting prescribing might actually increase the nurse’s workload with the current handwriting system and, therefore, this apparent lack of promotion could be a protection mechanism for nurses managing busy caseloads. Computerised prescriptions being piloted in some areas of the country should address this.

Although there was an overwhelming acceptance of nurse prescribing, the participants identified some terms and conditions they felt to be important. The first was the need for the nurse to be competent and understand what they are prescribing:

- ‘There’s no problem as long as the nurse is competent.’

Part of the patient’s agenda appears to be the need for nurse prescribers to be educated and competent. One of the most important recommendations of the Crown Report (DoH 1999) was concerned with this very issue. The consultation paper on nurse prescribing (DoH 2000a) also identifies not only the need for an educational preparation process, but also a robust continuing professional development programme. If competence and education are high on both the patient’s and the government’s agendas, the delivery of this service might strengthen the skills and expertise of the nurse prescriber as well as public confidence.

Five (10 per cent) of the participants were happy that nurse prescribing was limited to ‘more simple things’:

- ‘I would be happy for the nurse to treat minor ailments but would go to the doctor for anything serious.’

Equally, the same number of participants identified that nurse prescribing could go further. Suggestions included extending prescribing rights to other groups of nurses, such as stoma nurses and psychiatric nurses. One participant stated that nurses should be able to prescribe the things they use:

- ‘If they can’t trust her to write a prescription, then they shouldn’t trust her with the job.’

**Gains and benefits** Participants also identified gains or benefits for the nurse being able to prescribe. The most commonly identified gain (72 per cent of participants) was timeliness of treatment. What the participants liked was the responsiveness to their particular need, with the majority of participants getting an assessment by the nurse and a prescription in the same day. This also meant that they were able to start treatment sooner:

- ‘You can get it when you need it with the nurse.’

This was also a finding of Luker et al (1997b). However, from a cost benefit viewpoint, as nurse prescribing is currently limited to minor treatments, it is open to debate whether all treatments needed to start straight away and whether some of the illnesses would have improved without a prescription. As in this example, cost benefits might conflict with the patient’s needs and wants. What this timeliness of treatment does demonstrate is evidence of a flexible way of working that maximises the talents of the NHS in providing better services for patients as ascribed to in The NHS Plan (DoH 2000b).

Forty six per cent of the participants acknowledged better use of the GP’s and nurse’s time. Patients recognised that GPs were busy and that the more minor problems were best dealt with by a nurse prescriber, leaving the GP free to deal with more serious problems:

- ‘Some areas of care, for example nappy rash, it’s not the best use of the doctor’s time.’

There were only two participants who identified that nurse prescribing had benefits for nurses in terms of saving time. The nursing literature is not consistent on the benefits of nurse prescribing to the profession per se. For example, McCartney et al (1999) claimed nurse prescribing was little more than the transfer of routine medical work to nursing, whereas Courtenay (2000) has identified this a means of meeting the needs of the patients. Nurse prescribing, like the work of the advanced nurse practitioner, is work that was previously part of the medical
domain (NHSME 1993). However, from the evidence of this study and previous work, patients appear to be happy with the practical application of this, which it is hoped will reflect positively on the nursing profession.

Forty-six per cent of participants identified that nurse prescribing was more convenient. Convenience was cited by the prevention of a visit to the GP, with treatment centred on patients’ needs in their own homes. This relatively new method of service delivery now appears to make the previous system obsolete.

The participants also identified the quality of the nurse prescriber relationship as a benefit. This was characterised by the nurse being approachable, providing reassurance, continuity and providing information/health promotion details:

- ‘With the health visitor you can talk things over with them and you don’t feel such an idiot. Doctors are on a pedestal, whereas the health visitor is more approachable.’

This relationship reflected a consultancy type role in which the nurse exerted authority because of her expert knowledge and clinical competency. Humphris (1994) describes this as a process in which the consultant initiates the process and the recipient is then free to accept or reject the recommendations.

- ‘It’s up to parents to check what has been prescribed for their children anyway.’

The issue of patient consultations has been explored previously, although Rees and Kinnersley (1997b) found that the patients also claim little has been undertaken concerning their outcome. The findings from this study provide evidence that nurse prescribers were successfully meeting the needs of the patients/clients. Forty-nine (98 per cent) of participants were happy with the nurse prescribing process, which included consultation and effect of the prescription in remedying the problem.

Continuity of care was a further quality identified as part of the nurse prescriber relationship. Chapple et al. (2000) also identified continuity as important when exploring patients’ perceptions of nurse-led services:

- ‘Benefit for the child – a constant, not seeing other doctors.’

Luker et al (1997b) found that the participants also viewed the nurse prescriber as providing a quality relationship. The characteristics of the nurse and probably the setting (the majority of the prescribing occurred in the patient's home) had benefits for patients. In this and Luker's study, further information was provided — this was either practical advice about the treatment or health information. This approach might have increased compliance with treatment or equipped recipients with the information to be able to self-care and thus control or manage the treatment for which the prescription was issued:

- ‘She also went through all the things that may have caused my baby's itchy skin like a new baby bath or washing powder.’

Part of this quality relationship appeared to be advantageous in addressing the issue of under-reporting. This has been a recognised problem within the medical professions, as patients remain reluctant to inform doctors of what they perceive to be minor or less serious problems (Cartwright and Smith 1988, Luker et al 1998) and also have difficulty in getting to see GPs (Luker et al 1998). The nurse prescribing relationship appeared to redress this.

A further benefit identified was the practical approach of the nurse prescriber. The participants said nurse prescribers knew the system and best methods of delivery to make sure that they got maximum benefit from the prescription:

- ‘The nurse also arranged the prescription as I had the wrong bag when I came out of hospital. She called the chemist at 6pm and the bags were ready to be collected first thing in the morning.’

The advanced nurse practitioner literature also reflected the practical approach of nurses claiming that this was due to their positive interpersonal skills which enabled them to make the system work by resolving and working around the problems (Mallison 1984).

The participants also identified the expert role of nurse prescribers. They viewed them as experts within the realms of wound care, catheter care, nappy rash, mastitis, thrush, and common complaints in mothers and babies and dry skin/eczema. Nurse prescribers were deemed to be experts by the participants because they dealt with the problems regularly, they were knowledgeable and practical, and could provide alternatives if the original treatment didn’t work.

Finally, the participants identified the nurse prescribers’ awareness of their professional limitations as a benefit:

- ‘The health visitor knows all about the babies and minor things and also knows if it is serious and if you need to see a GP.’

These working practices might well explain why patients who identified that they did not know what nurses could prescribe did not go on to identify it as a concern. It appeared that the nurse prescribers made the patients aware of what they could and couldn’t do. If it was beyond their expertise they then recommended that patients went to see their GP.

Again, these findings are pertinent in light of the nurse prescribing consultation paper (DoH 2000a). One of the options of this paper (Option 5) is about extending prescribing rights to include the entire general sales list, pharmacy medicines and all licensed prescription-only medicines with the exception of controlled drugs. This option
proposes that, like dentists and doctors, nurses will use their professional judgement to decide which medicine a patient needs, and whether they are competent to prescribe. Participants in this study identified that this recognition of personal limitations already occurs with nurse prescribing in its current form. This recognition might continue regardless of the range of medicines that nurse prescribers have access to.

**Disadvantages** The participants finally reflected on any disadvantages or limitations with the current system of nurse prescribing. Sixty per cent of participants were happy with nurse prescribing in its present state and were unable to identify either disadvantages or areas for improvement. This in itself is positive and affirms that nurse prescribing was meeting the need of the majority of these recipients.

The remaining 34 per cent identified areas for further nurse prescribing rights, which would make the service more seamless. The suggestions made included prescribing for the under-fives, repeat prescriptions, antibiotics if the treated wound became infected, and eye ointment. Only one participant felt that nurses should be able to prescribe the same as doctors.

Interestingly, when patients talked about extended prescribing rights, the word that was used repeatedly was continuity. The participants saw the nurses as carrying on the work of prescribing. This reflects one of the recommendations of Crown Report Two (DoH 1999), in which dependent prescribers will be authorised to prescribe certain medication for patients whose condition has already been assessed by an independent prescriber. The perceived benefits were in terms of:

- Providing more holistic care, as in the case of a wound being treated by a district nurse ‘including antibiotics if it became infected’.
- A more convenient service ‘requiring more than one treatment but you have to get one from the nurse and one from the GP’.

Again it appears that some of the patients’ views in this study were synonymous with the government’s proposals. The nurse prescribing consultation paper (DoH 2000a) has proposed options for the nursing profession among others to consider in relation to patient safety, better and more convenient care. The formulary in its current format was not able to meet all of the participants’ needs. The findings from this study suggest that nurse prescribing could be expanded.

Finally, 26 per cent of the participants highlighted training issues in relation to justification for and against further expansion to nurse prescribing. They recognised that medical training equipped doctors (unlike nurses) to prescribe without any restrictions. Participants stated that nurses would need to undertake further training if they were to extend prescribing rights at a later date. This issue has been recognised by the Crown Report (DoH 1999), the DoH (2000a) and the English National Board (1991).

**Conclusion**

This study has identified how nurse prescribing in one PCG in Leicestershire is working from the patient’s/client’s point of view. The participants in this study were mainly low users or new to the experience of nurse prescribing. This did not appear to affect their reflections on current or future service delivery of nurse prescribing.

Suggestions for the future development of nurse prescribing also reflected government concerns. This study has also been important locally in affirming to the nurse prescribers that prescribing, as part of their everyday practice, meets the needs of the service users with positive experiences in terms of the process and the outcome.

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**REFERENCES**


