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ABSTRACT

Aim

To explore the consultations between nurse prescribers and dermatology patients.

Background

Communication skills, consultation time, information, and follow-up are central to the treatment management of dermatology patients. The contribution nurses make to the care of these patients has significant potential. Research has not explored the consultations of nurse prescribers with dermatology patients.

Method:

A multiple case study of 10 practice settings across England in which nurses prescribed medicines for dermatology patients. Data comprised of semi structured interviews (n=40), patient questionnaires (n=165/200) and video-taped observations of nurse consultations (n=40). Data analysis included thematic analysis, descriptive statistics, Chi-square and non-parametric tests. Data were collected between June 2006 and September 2007.

Findings:

Nurses believed that their holistic approach to assessment combined with prescribing knowledge, improved prescribing decisions. Listening and explanation of treatments were aspects of nurse communication rated highly by patients. Listening and dealing sensitively with emotions were also aspects of the video-taped consultations rated highly by assessors. Nurses were less consistent in providing information about medicines.

Conclusion:

Triangulated data from this study confirms that nurse prescribing enhances the care of dermatology patient through improved prescribing decisions. If patients are to be more involved in this decision making, nurses must provide them with more information about their medicines. Benefits provided by prescribing are most evident in the practices of dermatology specialist nurses. Further evidence is required to identify whether prescribing offers specialist nurses in other therapeutic areas similar benefits.

SUMMARY

What is already known about this topic

- Communication skills, time, information giving and follow-up are of central importance in the treatment management of dermatology patients.
- Over 70% of nurse prescribers, prescribe medicines for dermatology patients
- Nurse prescribing is expected to enable a more holistic approach to care with greater opportunity for patients to be involved in treatment decisions.

What this paper adds

- Nurses believe that their knowledge and expertise in caring for patients with dermatology conditions, combined with prescribing, enhances patient care through improved prescribing decisions
- Listening skills and the provision of emotional support are communication competencies demonstrated by nurse prescribers, however, nurses need to be more consistent in providing information about medicines and their side effects, enabling patients to become more involved in decision making about treatment options
- The benefits provided by prescribing are most evident in the practices of dermatology specialist nurses

Implications for practice and/or policy

- Prescribing makes better use of nursing skills and enhances patient care which supports the aims of UK prescribing policy

- The communication competencies demonstrated by nurse prescribers suggest that nurses attempt to understand the patient perspective and so adopt a concordant approach to medicine taking.
- Prescribing optimises the role of dermatology specialist nurses enabling them to contribute more effectively to dermatology services

INTRODUCTION

Common skin complaints have increased over the last 2 decades and general Practitioner (GP) consultations for these conditions have risen (Department of Health (DoH) 2007). They are the fourth commonest reason for seeing a GP and it is estimated that each year 15% of the population see their GP for these conditions (DoH 2007). Only 2-3% will need to be seen by a specialist in secondary care (Dermatological Care Working Group (DCWG) 2001).

Patient information is key to the successful management of skin disease and this includes allowing sufficient time for explanation about the nature of the disease and the need for appropriate treatment. Time constraints placed on doctors' means that they are frequently unable to meet the demands of the high number of patients with these conditions.

It is evident that nurses have lead roles to play in the delivery of dermatology services and prescribing has optimised the roles of these nurses (Courtenay & Carey 2006). Appropriately qualified nurses in the United Kingdom (UK) now have virtually the same prescribing rights as doctors. Nurse Independent Prescribers (NIPs) can

independently prescribe any licensed medicines (and some controlled drugs) for any condition (DoH 2005). Nurse Supplementary Prescribers (NSPs) can prescribe any medicine for any condition in partnership with a doctor and provided that the medicine is listed on the patient's Clinical Management Plan (CMP) (DoH 2002). Although legislative developments in a number of other countries (e.g. Sweden, Canada, Australia, and America) do enable nurses to prescribe medicines, they do not provide nurses with such extended prescribing rights as nurses in the UK.

A survey conducted in the UK in 2005 (Courtenay et al 2006) found that nearly 75% of nurses qualified as NIPs/NSPs prescribe medicines for dermatology patients. Although the contribution nurses make to the care of dermatology patients through nurse-led clinics has been explored (Courtenay & Carey 2006), and a small number of studies have explored the consultations of nurse prescribers (Bradley & Nolan 2007, Stenner & Courtenay 2008), there is a dearth of evidence exploring nurse prescribers' consultations with dermatology patients.

BACKGROUND

Evidence suggests that clinical outcomes for dermatology patients (e.g. patients with atopic eczema (AE)) could be improved if patients were given more information and time (Courtenay & Carey 2006). Targeted patient education by a specialist dermatology nurse was examined by Broberg et al (1990). Although the study was not double-blind and so the design weakened, a significant reduction in the severity of AE in the patients who received the targeted education was reported. Education and demonstration of topical therapies by a specialist dermatology nurse resulted in reduced severity of eczema and increased use of emollients in a study by Cork et al

(2003). Although not a randomised controlled trial (RCT), Cork et al (2003) concludes that this work reinforces the important role of specialist dermatology nurses and that the most important intervention is to listen to the patient, explain the disease, and demonstrate how to apply topical therapies. More recently, questionnaires were used by Lester (2001) and McEvoy (2004) to evaluate the satisfaction of patients attending a nurse specialist in dermatology. Although response rates were less than 50%, 108 participants responding across the 2 studies, **patients** ~~?remove~~ reported they appreciated the practical support with regards to how to apply ointments and creams and over half felt they had been given more advice than by their GP.

A systematic review by Horrock's et al (2002) examining the extent to which **?a** primary care nurse **? or practitioners** were able to provide care for patients with AE equivalent to doctors, identified that patients were more satisfied with the care they received from nurses. Although there was no difference in health status, nurse practitioners had longer consultations. Additionally, nurse practitioners scored better on communication skills than doctors. Horrock's et al (2002) concludes that this could have lead to improved patient education and a greater understanding by patients of their illness and treatments, increased adherence and self care. However, the authors point out that ambiguity existed across the studies reviewed with regards to the role and preparation of nurse practitioners. Although patient satisfaction could have been related to longer consultation times, it could also have been related to the training and experience of the nurse. Therefore, there is a need to elucidate the factors that lead to the increased satisfaction with nursing care identified by patients in the studies reviewed.

Although not specific to dermatology, several self report studies have explored the consultations of nurse prescribers. It is evident from this work that nurses and doctors believe that nurses give more advice to patients about their condition and treatment than doctors (Luker & McHugh 2002, Avery et al 2004). More recently, Bradley & Nolan (2007) and Stenner & Courtenay (2008) report that nurses believe prescribing enables a more holistic approach to care and greater opportunity for patient involvement. Stenner & Courtenay's (2008) findings suggest that this holistic approach may enable prescribing decisions to be more appropriate to patients' individual needs, improving efficiency and concordance.

Evidence indicates that communication skills, time, information giving and follow-up are of central importance in the treatment management of dermatology patients. The contribution nurses can make to the care of these patients has significant potential. Indications are that nurse prescribing enables a more holistic approach to care and greater opportunity for patients to be involved in treatment decisions; however there is no evidence specifically exploring the consultations of nurse prescribers with dermatology patients. This is important given the high number of patients with skin conditions treated by these nurses.

THE STUDY

Aim

To explore the consultations between nurse prescribers and dermatology patients.

Design/methodology

The data reported here were collected from Phase 2 of a larger study designed to explore the treatment management of patients with dermatological conditions by nurse prescribers. Phase 1 involved a national survey of extended independent and supplementary nurse prescribers (Courtenay et al. 2007, Carey et al 2007, Courtenay et al 2006). Phase 2 employed multiple methods of data collection within case studies (n=10) of practice settings in which nurses prescribed medicines for dermatology patients i.e. a collective case study design (Stake 1994).

Sample/participants

Selection of case sites was determined by criteria based on findings from the national survey (Courtenay et al. 2007, Carey et al 2007) that the type of nurse and setting, this sentence does not seem to make sense specialist training, mode of prescribing, and dermatology conditions varied across nurses who prescribed medicines for dermatology patients. Selection criteria included nurses from primary and secondary care settings, nurses with and without specialist training in dermatology, nurses who have used NIP and/or NSP for a range of dermatological conditions, a range of geographical areas in England including urban and rural locations- not sure this is strictly true as non of the areas were rural-perhaps best just to say a range of geographical areas

In order to take each of these criteria into consideration, and select a sample of case studies representative of a national perspective, it was identified that 10 case studies would be required. Previous research (Latter et al 2005) adopted a survey and case study design to explore Independent Extended nurse prescribing. These researchers similarly used a purposive sample of 10 case study sites, an independent extended

nurse prescriber forming the focus of study at each site. These information-rich cases enabled meaningful comparisons to be made, illuminating the research questions under investigation by these researchers.

Nurses within each case site were asked to videotape 5 patient consultations and disseminate 20 questionnaires to a range of dermatology patients or parents/carer of a child (including the 5 patients whose consultations were videotaped). Both the range of dermatology conditions and frequency of prescribing by nurses were evident from the national survey (Courtenay et al. 2007, Carey et al 2007). It was clear therefore that the number of consultations nurses were asked to videotape and questionnaires they were required to distribute would be practicable within the data collection period at each case study site. Additionally, a sample of 50 video-taped consultations and 200 questionnaires across the 10 case study sites would reflect the dermatology patients for which these nurses prescribed. Semi structured interviews took place with the nurse prescriber and members of the healthcare team who worked alongside the nurse prescriber at each case study site. Case study data collection took place between June 2006 and September 2007.

Data collection methods and data analysis

Semi structured interviews

The semi-structured interview schedule was informed by a review of the relevant literature and also the findings from the completed national survey (Courtenay et al 2007). Thematic analysis was conducted on the data (Braun & Clarke 2006, Pope *et al.* 2006). Initial coding and categorising of data was managed by the ATLAS.ti qualitative data analysis software. This was followed by discussion and identification

of cross-cutting patterns and themes. Interview data were read in conjunction with the other data sources in order to develop conceptualisations of possible relationships. Patterns, themes and contrasts emerged. Reliability was enhanced by the independent assessment of transcripts by two skilled qualitative researchers. Minor differences in assessment were consolidated through discussion.

Video-taped observations

A dermatology medical consultant and a dermatology nurse consultant assessed each video-taped consultation using a structured observation tool, adapted from previous work in the area of nurse prescribing (Latter et al 2005), and containing the necessary competencies for prescribing as outlined by the National Prescribing Centre (NPC) (NPC 2001). The checklist of competencies were sub divided into 3 areas i.e. assessment and diagnosis, communication, and prescribing practice. Each assessor rated the various aspects of the consultation using '1' = 'accurate, confident, safe practice', '0' = 'not done/omitted/ not seen/unsafe practice' or 'N/A' = 'not applicable to this practice/condition'. Inter-rater reliability was enhanced through pilot work and discussion about how to use the tool between the researchers and the 2 assessors. Descriptive statistics were used to analyse data.

Patient questionnaire

A previously validated questionnaire (General Practice Assessment Questionnaire for Nurses 2003), adapted for dermatology patients, was distributed to patients at case study sites. The questionnaires sought patients' views on the speed of access to their usual nurse, continuity of care, and various aspects of communication during their consultation with the nurse. Patients completed and posted questionnaires

anonymously into a box at the clinic receptions before leaving. Data collected was in the form of 6 point Likert-type scales and analysed using SPSS. Procedures undertaken included descriptive statistics, Chi-square and non-parametric tests.

Ethical considerations

The study was approved by the appropriate university and National Health Service (NHS) research ethics and research governance committees. Participants in the national survey were asked to indicate if they would be interested in participating in phase 2 of the research. Those that expressed an interest, and met the sampling criteria, were contacted to confirm their willingness. Once support to participate had been provided by nurse's managers, participants were provided with an introductory letter and the project protocol. Members of the healthcare team who worked alongside the nurse prescriber at each case study site were also approached and asked to participate in an interview. Consent was gained prior to all interviews. Nurses recruited patients and gained patient consent before filming the consultation. Prior to gaining consent, nurses explained to patients that participation was voluntary, that they were free to withdraw at any time without giving a reason, that a decision to withdraw would not affect the standard of care they received

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Rigour

Triangulation of methods and data sources confirmed the accuracy of the data set (Denzin & Lincoln 1998). Additionally, the data provided something other than scaling reliability and convergent validation; it provided a more holistic portrayal of the phenomenon under study and stimulated further analysis (Denzin & Lincoln 1998,

Sandelowski 1995). Interim findings were presented at meetings of the British Dermatology Nursing Group (BDNG) prescribing sub committee (members of whom were involved in data collection at case study sites) in 2006 and 2007. This enhanced the credibility, robustness, and trustworthiness of the research process and emerging categories and themes. Categories and themes, arising from initial data analysis were explored and tested throughout data collection (Murphy et al 1998).

FINDINGS

Nurse prescribers at case study sites included Dermatology Specialist Nurses (DSNs) (n=4) and a Dermatology Nurse Consultant working across both primary and secondary care. Practice Nurses (PNs) (n=3) (two practice nurses worked in one site) and Nurse Practitioners (NP) (n=2) working in primary care (see Table 1). Across the 10 case study sites 40 video taped consultations were collected including practice nurse (n=9), nurse practitioner (n=6), dermatology specialist nurse (n=20), dermatology nurse consultant (n=5) (see Table 1). However, three of the consultations were incomplete (i.e. the nurse had only recorded a small part of the consultation) and so were not included in the analysis. Each nurse prescriber was well established in her role and had between 1 and 4 years experience as a prescriber.

Video taped consultations included patients experiencing both one off treatments and long-term care. Those patients requiring one-off treatments predominantly had minor skin conditions and were seen by nurse practitioners and practice nurses. By contrast, patients with chronic skin conditions which required long-term care were generally treated by specialist nurses.

One hundred and sixty five (83%) completed patient questionnaires were returned. Semi structured interviews took place with the nurse prescriber (n=11), (although a problem with recording equipment at one site meant only 10 interviews were transcribed and analysed) and members of the healthcare team who worked alongside the nurse prescriber at each case study site (see Table 1).

Three themes emerged from the analysis: ‘listening to patients and relationships’, ‘access & continuity’, ‘medicines information and shared decision making’.

Quotations are used to illustrate themes in the analysis. To protect anonymity, names have been replaced by an ‘x’, cs refers to case study site. Participant groups have been abbreviated to Dr=doctor, NP = nurse prescriber, AS=administrative or reception staff.

Listening to patients and relationships

The relationship that nurses were able to develop with dermatology patients was of central importance to prescribing decisions. Effective communication, nurse consultation style and continuity of care each contributed to effective nurse-patient relationships

Evidence that nurses listened to the patient during the consultation and offered support and information was provided by the videotaped observations of practice and the patient questionnaire (see Tables 2 & 3). All aspects of communication, where applicable, were assessed as having occurred in the majority of video-consultations

(Table 2). No omissions occurred for the competencies of ‘listens and understands patient beliefs and expectations’, ‘deals sensitively with patient’s emotions and concerns’, ‘gives clear instructions about medication and how to apply if required’, or ‘shows evidence of understanding cultural, language & religious implications of prescribing’.

All 10 aspects of communication (Table 3) rated in the patient questionnaire showed large skewed distributions towards the positive end of the scales, with no negative ratings. The highest ratings (of very good/excellent) were given for ‘how well the nurse explained problems or treatment’ (93%), ‘how well the nurse listened’ (92.1%), ‘how well at ease the patient felt during the consultation’ (91.7%) and ‘the nurses caring or concern’ (91.5%).

Nurses and doctors reported in the interviews that they believed nurses had a different style of consultation to doctors in that they were more approachable, better at listening to the patient and offered patients greater support. This consultation style, which included paying attention to the patients’ medical history and lifestyle, was seen as an important means of pinpointing the most appropriate treatment when prescribing:

The nurse can be more sympathetic, more supportive, in an ideal world the nurse would have more time, but the nurses here are also under time and pressure. But they all take a different approach, a supportive role sounds a bit more demeaning, but it is really important. (cs2Dr)

Nurse prescribers reported that building a rapport with patients was an important element of the nurse consultation and this was sometimes enhanced where nurses had the opportunity to establish longer-term relationships with patients. Where continuity of care was possible, nurses were able to develop a better understanding of the patient's history and lifestyle. This in turn meant they were able to make a more detailed assessment about the patient's skin condition and ultimately to make more appropriate prescribing decisions.

Access and Continuity

Patient questionnaire results showed the majority of patients (67.7%, n=107) rated access to nurse services as very good or excellent (see Table 4). Forty seven (30.1%) patients reported that they were able to see the nurse on the same day, 20 (12.8%) by the next working day and 59 (37.8%) reported that they were able to book their appointments in advance (see Table 4). It was also evident from data collected from patient questionnaires, that there was a significant difference in the way patients were able to book appointments. Appointments for specialist nurses were mostly booked in advance, whereas appointments for nurses in general practice tended to be booked on the same day ($p<0.0001$).

Continuity of care was also highly rated by patients: 78% rated access to their usual nurse as very good or excellent (Table 5). 'Always' seeing their usual nurse was rated highest by patients. Table 5 illustrates that the majority of patients were able to see the same nurse on different occasions. Of 141 patients, 45 (31.9%) always saw their usual nurse, 29 (20.6%) almost always did so and 24 (17%) saw their usual nurse a lot of the time.

Continuity patterns differed significantly between specialist and general practice nurses. More patients seeing a specialist nurse reported that they ‘always’ saw their usual nurse. These patients tended to have conditions requiring long-term treatment as opposed to the patients of general practice nurses who were more likely to have conditions requiring one-off treatments. It was evident from interview data that this difference meant that specialist nurses were more able to develop long-term relationships with their patients, although NPs and PNs also reported in interviews that there was a degree of continuity as they were involved in other aspects of patients care such as chronic disease management, contraception and immunisations. It was also apparent from interview data that developing ongoing relationships with patients was said to enhance quality of care and improve concordance:

If they have any major problems sometimes X will certainly do some visits, that sort of thing. She can establish a rapport with the family, get to know them and encourage them to keep going with their plan. (cs3Dr)

The amount of time nurses were able to spend with dermatology patients was rated as very good or excellent by 85.9% of patients completing patient questionnaires (see Table 3). Lengths of consultations were variable depending on the nature of their condition and the case study setting, and lasted between 10 and 30 minutes. Administrative staff and doctors reported in interviews that in some cases the length of patient consultation tended to be more flexible for nurses than doctors, although adopting the prescribing role was not reported to have resulted in any change in length of consultation:

She is allocated the same amount of time, yes, but she does seem to spend that little bit more time with them (cs7AS)

The nurse can spend more time with the patient. She can adjust her times accordingly. (cs5dr1)

Nurse prescribers reported in interviews that longer nurse consultations provided an opportunity to offer broader health education advice to patients and also, in the case of specialist nurses, encourage adherence to the long-term treatment regimes of chronic skin conditions:

Somebody rang me up controversially saying these Nurse Led Clinics, it's just a doctor's job, and I said 'You tell me when you had twenty minutes to sit and talk to a patient. Even on the ward you never had that. So you tell me it's not nurse led and you are looking at somebody with acne and you are checking their moles, you are telling them about sun protection, you are telling them about drinking, so is that not health education?' So I think it has given us all the things that we are supposed to have in the Code of Practice, it gives you time to do it, so I think it is quite advantageous really for that. (cs10NP)

Medicines information and shared decision-making

Specialist nurses, more so than nurses in general practice, reported in interviews, that they learnt from their prescribing decisions and so increased their knowledge of treatment options available to dermatology patients. As nurses gained knowledge and

experience through prescribing, they were able to prescribe from a wider range of medicines than they had previously been able to offer patients for dermatology conditions:

I have learnt to move on to different drugs that I probably wouldn't have been able to offer the patient before. (cs10NP)

Nurse prescribers reported in interviews that continuity of care within long-term relationships was said to enhance learning:

The beauty of a nurse role is we have that continuity. We do tend to manage our own caseloads, so you do see these patients back. So you do see the outcome of your consultation and your prescribing. (cs9NP)

Specialist nurses (and one nurse in a general practice setting) reported that compared to doctors, they were inclined to spend more time working with patients to find the right treatment option:

I feel that I can take my practice a bit further because, for instance, I now can sit with people I have looked after a long time that have probably come up to now using systemic therapy, and I know the patient because I have seen them regularly (whereas the doctors have to keep changing) and we can discuss in great detail. It is an open discussion and, you know, they might like to drink and they have told me they do, so I can look at other drugs. The consultation I

think is quite professional and much more advanced than perhaps it used to be. (cs3NP).

I like to make the decisions with the patients and I think that's a lot of it, particularly with skin, because it's about liking the product a lot of the time and wanting to use it rather than it being something that somebody has given to you saying "you will use this". So we do a lot of working through the products to find the one that they like, and the one that they are going to use, and the one that works. I'm prepared to do that work with them whereas maybe a doctor wouldn't necessarily. So we do have that concordance together. I suppose that we come together to decide what they are going to use and what's working, and I think that really helps because it definitely reduces the problems with the eczemas if you get them on a regime that they like. (cs5NP)

In comparison to findings from interviews, there was inconsistency from the other data sources in the extent to which nurses gave clear instructions about side-effects. While nurses claimed to spend more time working with patients to help them make informed choices about treatments, certain aspects required for enabling informed choice were not assessed as being included in all video-consultations (see Table 2). These were 'gives clear instructions about possible side effects and action to take' (not evident in 4 consultations), 'identifies present and future needs and evidence of planning a strategy to meet these needs (not evident in 3 consultations), 'explains nature of condition and potential risk and benefit of treatment options (not evident in 2 consultations) and 'helps patient make informed choice about treatment (not evident

in 1 consultation). However, clear instructions about medication and how to use it were given in all consultations where this was applicable.

All communication aspects related to decision-making were rated positively in the patient questionnaire (Table 3). The extent to which nurses explained the patient's problems and treatment was rated highest by patients (93.2%). When examining the frequency of responses (by combining the number of people selecting very good/excellent), the items 'how much you were involved in the decisions about your care' (87.7%), and 'the amount of information you were given about your medicines' (83.4%) were rated marginally lower than other items. Interestingly, patients of specialist nurses rated this aspect of communication significantly higher than patients of general practice nurses ($p=0.005$).

DISCUSSION

Three general practice nurses working in minor illness clinics, found it disruptive to their workload to use the video recorder during consultations. Only 5 video-taped consultations were collected between these 3 nurses.

It was thought that asking patients to complete questionnaires immediately following their consultation would achieve a higher response rate than a postal questionnaire. Although participants were informed that the nurse would not be aware of their responses, they may have wanted to gratify the nurse. This could have introduced some degree of positive reporting bias.

The evidence suggests that specialist nurses, the majority of whom were able to provide longer, flexible consultation times and continuity of care for patients with chronic skin conditions, combined their high levels of knowledge and expertise with their prescribing skills to enhance patient care. There was evidence of learning through prescribing, improved decision making, and use of appropriate medicines. These benefits, which were highlighted in interview data, were confirmed in findings from the video-consultations and patient questionnaire. The findings re-assert the contribution specialist nurses can make to the care of dermatology patients and support the aims of recent UK policy on the provision of dermatology services (DoH 2007). There was, however, less evidence of these benefits in the consultations of general practice nurses. Although nurse prescribing was contributing to more efficient service delivery in general practice and patients were satisfied with the service provided, a narrower range of benefits were reported. These nurses tended to have shorter consultation, predominantly dealt with minor skin conditions and had less formal training in dermatology.

The relationship nurses had with patients was an important feature of their consultations. Communication competencies demonstrated by nurses during a high percentage of patient consultations included listening skills and the provision of emotional support i.e. those in keeping with traditional nursing roles (Stenner & Courtenay 2008). These competencies, combined with improved access and continuity of care, placed nurses in the unique position of developing a very good understanding of the patient's perspective and so a holistic and accurate assessment of patients needs.

The quality of the relationship that nurse prescribers have with their patients and the opportunity nurses have to engage with their patients and make an accurate assessment of need has been highlighted previously (Brookes et al 2001, Luker et al 1998, Bradley & Nolan 2007). However, it is evident from our findings that it is the combination of holistic assessment with nurses prescribing knowledge and expertise that leads to prescribing decisions that are more likely to be embedded within the context of the patient's life. By adopting the role of prescribing (involving more medical knowledge) it appeared that nurses in our study had, as described by Jones & Jones (2006), bridged the gap between nursing and medicine which, in turn, gave rise to more appropriate prescribing decisions. This was particularly evident in the prescribing decisions of specialist nurses who were frequently involved in the treatment management of chronic skin conditions. The prescribing knowledge and expertise of these nurses meant that they were confident to talk to dermatology patients' about their medicines. They learnt both from these discussions and their prescribing decisions, and became more aware of the range of dermatology treatment options available.

Nurses claimed that they were inclined to spend more time than doctors working with dermatology patients to help them make decisions about their care. However, our findings show that although nurses reliably provided patients with information about their present and future needs, problems and treatments, and instructions about taking medicines, they were less consistent in involving patients in decision making and providing information about medicines and their side effects. It could be argued that some of the patients who saw NPs and PNs did so for conditions that required one-off treatments and so may have required less information about medicines. Alternatively,

patients with chronic skin conditions may well have been provided with information about treatment options in prior consultations. Certainly, all aspects of communication were rated highly by patients, with slightly lower ratings given to aspects of informed decision making.

The role that patient information plays with regards to adherence to medicines has been highlighted previously (DoH 2001). The need for nurse prescribers to provide patients with information about their medicines, specifically information about side-effects, has also been reported (Berry *et al* 2006, Berry *et al* 2008). Medicines information has been identified as an important influence on the use of topical medications by dermatology patients (Gradwell 2001), inadequate information resulting in poor concordance (Titman 2001, Buchanan 1998). The time required for some of these medicines to take effect, odour, appearance, consistency and frequency of application, can add to this problem. Therefore, although the information needs of dermatology patients experiencing one-off and long-term conditions are different, if these patients are to make informed choices about the treatment options available, they must be provided with the necessary information about their medicines as well as instructions about how to apply and/or use them.

CONCLUSION

Triangulated data from this study confirms that nurse prescribing enhances the care of dermatology patient through improved prescribing decisions. However, if patients are to be more involved in this decision making, nurses must provide them with more information about their medicines. The benefits provided by prescribing are most

evident in the practices of dermatology specialist nurses. Further evidence is required to identify whether prescribing offers specialist nurses in other therapeutic areas similar benefits. As in this research, evidence available from the patient perspective on nurse prescribing has involved questionnaire surveys. Further evidence, such as interview data exploring some of the closed ended (or fixed alternative) responses given by patients- I am not sure what this means, as all the responses were closed and fixed??, and providing a richer and fuller perspective from the patient, is required. Although the role of the nurse in the prescription of medicines differs across the world, our findings may have implications for those responsible for planning services for dermatology patients in other countries.

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Table 1: Data collected from each case study site

Case Study	Job Title	Number of nurses	Patient Questionnaires	Video –taped consultations	Interviews			
					Nurse prescriber	Doctor	Admin staff	Non-nurse prescriber
1	DSN:	1	17	5	1	1	1	X
2	PN	2	9	2	2	1	2	1
3	DSN	1	15	10	1	1	1	1
4	NP	1	25	1	1	1	1	X
5	NP	1	19	5	1	2	1	X
6	PN	1	25	5	1	1	1	1
7	PN	1	2	2	1	X	1	1
8	DSN	1	23	5	1	1	1	1
9	DNC	1	25	5	1	3	1	1
10	DSN	1	5	5	1	1	1	X
Total		11	165	40	11	12	11	6

Code DSN=Dermatology Specialist Nurse, PN=Practice Nurse, NP= Nurse Practitioner, DNC Dermatology Nurse Consultant

Table 2: Patient videotaped consultations

Total 'n' represents number of consultations with agreement between assessors	YES		NO		N/A		Total n=
	%	n	%	n	%	n	
Listens and understands patient beliefs & expectations	100	33	0	0	0	0	33
Deals sensitively with patient emotions & concerns	100	32	0	0	0	0	32
Helps patient make informed choice about treatment	89.5	17	5.3	1	5.3	1	19
Explains nature of condition and the potential risks & benefits of treatment options	92.0	23	8.0	2	0	0	25
Gives clear instructions about their medication and how to apply if required (dose, use & duration)	96.6	28	0	0	3.4	1	29
Gives clear instructions about possible side effects & action to take in event	75.0	15	20.0	4	5.0	1	20
Shows evidence of understanding cultural, lang. & religious implications of prescribing	36.4	4	0	0	63.6	7	11
Identifies present & future needs and evidence of planning a strategy to meet these needs	90.3	28	9.7	3	0%	0	31

Table 3: Patient questionnaire: ratings of communication with the nurse

Table 4: Access to nursing services

Arranging an appointment	n= number of responses	% of responses
appt booked in advance	59	37.8
same day	47	30.1
next working day	20	12.8
within 2 working days	19	12.2
within 3-5 working days	11	8.1
Total	156	100
Ratings of appointment arrangement		
poor/ very poor	3	1.9
fair/good	48	30.4
very good/ excellent	107	67.7
Total	158	100

Table 5: Continuity of care

How often do you see your usual nurse?	n= number of responses	% of responses
always	45	31.9
some of the time	32	22.7
almost always	29	20.6
a lot of the time	24	17.0
almost never	11	7.8
Total	141	100
Ratings of 'how often do you see your usual nurse'		
poor/ very poor	1	0.7
fair/good	29	21.2
very good/ excellent	107	78.1
Total	158	100