NURSES AND DOCTORS VIEWS ABOUT THE PRESCRIBING PROGRAMME

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ABSTRACT

It is evident that nurses from a variety of clinical backgrounds are entering the prescribing programme and these nurses are prescribing medicines across a broad range of therapy areas. A number of studies have explored the educational preparation for the prescribing role and findings include variations across programmes with regards to course content and concerns surrounding the support provided by designated medical practitioners.

Aim

To explore the views of doctors and nurses, who care for people with diabetes, about the prescribing programme.

Design and methods

Interviews with 10 nurse prescribers, 9 doctors and 3 non nurse prescribers were conducted in 9 case study sites across England between October 2007 and September 2008.

Findings

Prescribing was seen as a natural extension of advanced nursing roles. Nurses considered it important to obtain sound knowledge in areas in which they intended to prescribe prior to undertaking the course. Variation across prescribing programmes with regards to the level of work required of students and the way in which courses were run were reported. Most doctors thought it beneficial for nurses to be involved in mentorship, although doctors continued involvement was considered necessary.

Conclusion

Prescribing supports advanced nursing practice. Nurses considering undertaking the prescribing course need to be aware of the variations across prescribing programmes with regards to the level of work required. There is support for joint mentorship between nurse prescribers and doctors for students undertaking taking the prescribing course.

THE STUDY

INTRODUCTION

Training for the dual qualification of Nurse Independent Prescribing (NIP)/Nurse Supplementary Prescribing (NSP) was introduced in 2003. In the majority of universities and higher education institutions (HEIs) that run the prescribing programme, this learning is shared between other healthcare professionals who have prescribing powers (i.e. pharmacists and allied health professionals). Provided medicines are within the nurses area of competence, qualified nurse prescribers have been able to independently prescribe any licensed medicines (and some controlled drugs) and any medicine as a supplementary prescriber since 2006. Nurses using supplementary prescribing must do so in partnership with a doctor and patient and medicines must be listed in the patient's clinical management plan.

Preparation for the prescribing role comprises 27 taught days (although many programmes include a distant learning element) and 12 days learning in practice with a designated medical practitioner (DMP) over a 6 month period. Necessary course pre-requisites for nurses include:

- The ability to study at level 3 or degree level
- A minimum of 3 years experience as a qualified nurse of which the year immediately preceding the prescribing course must be in the area that the candidate will prescribe
- A DMP (with experience or training in teaching and/or supervising in practice) prepared to supervise them through the 12 days prescribing in practice
- Manager's agreement to undertake the course
- Be in a role in which upon qualifying would be expected to prescribe (Nursing and Midwifery Council (NMC) 2006)

Applicants must also demonstrate they are competent to undertake a patient history, and a clinical assessment and diagnosis (NMC 2006).

Several studies evaluating nurse prescribing have also looked at the training and preparation for this role. Cooper et al (2008), exploring the views of stakeholders involved in supplementary prescribing policy, training and practice undertook 43 semi-structured interviews with nurse and pharmacist supplementary prescribers, doctors, patient group representatives, academics and policy developers. Although stakeholders generally viewed supplementary prescribing positively, negative aspects of the prescribing programme related to limited timescale and content of the course, the lack of courses tailored to individual clinical specialities and variations between courses. Some nurses and pharmacists reported DMPs dilatory attitude towards supervision and a number of lecturers gave examples of retrospective or cursory signing of competency documents by DMPs.

The adequacy of the role of the DMP was examined by Ryan-Woolley (2007) in a postal survey of 1575 Macmillan nurses. Although only 12% of the sample were qualified prescribers, a quarter of these nurses said that the support they had received from the DMP during the prescribing course was inadequate. The criteria for selecting a DMP was explored by George et al (2008) in 2 focus groups (n=5&7) of supplementary prescribing pharmacists and telephone interviews with 13 DMPs. It was evident from the findings that the main criterion was prior working relationships rather than previous mentoring experience, as set out by the Royal Pharmaceutical Society of Great Britain (RPSGB 2006). Support for nurse prescriber's involvement in the supervision of prescribing students is provided by Wells et al (2009). Nearly 30% of the 103 Irish mental health nurses completing a 13 item questionnaire

reported that they would like to be supervised by a clinical nurse specialist trained in prescribing. Only 17% of respondents favoured being supervised in their prescribing practice by their consultant psychiatrist.

It is evident (Courtenay & Gordon 2009) that nurses from a broad range of clinical backgrounds are entering the prescribing programme and these nurses are prescribing medicines across a number of therapy areas. It is therefore important to explore their views and experiences of the preparation for the prescribing role and also the views of those who have been involved in this preparation.

Aim

To explore the views of doctors and nurses, who care for people with diabetes, about the prescribing programme.

Design

A 2 stage study was undertaken to explore the treatment management of people with diabetes by NIP/NSPs. Stage 1 comprised a national questionnaire survey of NIP/NSPs. A collective case study design (Stake 1998), using multiple methods to collect data across 9 case studies of practice settings in which nurses prescribed medicines for people with diabetes, was employed in stage 2. Case sites were purposively selected on the basis of findings from the national survey in order to be representative of the settings in which nurses were prescribing for people with diabetes. This paper reports on a subset of data i.e. interview data with nurse prescribers, doctors and non-nurse prescribers (NNPs), collected during stage 2 of this study.

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Participants

Within each of the 9 sites, interviews were undertaken with nurse prescribers (n=10), a purposive sample of doctors (n=9) who supervised or supported a nurse prescriber, and NNPs (n=3) who worked alongside the nurse prescriber (see Table 1). Of the nurse prescribers, there were 4 Diabetes Specialist Nurses (DSNs), 4 nurse practitioners and 2 practice nurses. Of the 9 doctors, 3 were consultants in diabetes and 6 were general practitioners. Six had acted as the DMP responsible for educating and assessing a nurse through the prescribing course. Of the 3 NNP participants, 1 worked in a hospital setting and 2 in general practice.

Data collection

Issues identified in a review of the literature and findings from the completed national survey (Courtenay & Carey 2008) informed the interview schedules. Topics included the extent to which the prescribing programme met nurses' needs, how the course affected practice, whether or not the programme could be improved, and the views on doctors adopting the role of DMP. Interviews were conducted by two researchers (NC and KS) between October 2007 and September 2008.

Data analysis and rigour

Thematic analysis was conducted on the interview data (Braun & Clarke 2006, Pope *et al.* 2006). ATLAS.ti qualitative data analysis software was used to manage the initial coding and categorising of data. This was followed by discussion and identification of cross-cutting patterns and themes. Data saturation was achieved. Reliability was enhanced by the independent assessment of transcripts by two skilled qualitative researchers. Differences were minor and were consolidated through discussion.

Ethical considerations

The study was approved by university and National Health Service research ethics committees. Nurse prescribers who participated in the national survey were asked to indicate if they would be interested in participating in stage 2 of the research. Those that expressed an interest, and met the sampling criteria, were contacted to confirm their willingness. An introductory letter and the project protocol were given to participants once managers had agreed that they could participate. Doctors and NNP were first approached by the nurse prescriber in each case site, given an information sheet and asked if they were willing to participate. The researcher then arranged interview dates and also provided further explanation about the study and was able to answer any queries. Participation was voluntary and data made anonymous to protect the identity of participants or location of case sites.

FINDINGS

Analysis resulted in 3 themes: 1) Advancing nurse roles 2) Course content 3) Mentoring role Themes are illustrated by quotations that have been anonymised and coded according to profession and case study site. Abbreviations are Dr = doctor, NNP = non prescribing nurse, NP=nurse prescriber.

Advancing nurse roles

Prescribing was viewed positively by nurses and the prescribing programme was thought to be a natural progression for advanced nurses wishing greater autonomy. This is expressed in the following quotes:

“I think it is a natural progression because if you look at the role of the nurse now, even in a hospital setting, they probably don’t have as much access to doctors as when

I started training. I think for us to be recognised as a profession, with autonomy in each respected area. Again I think a senior nurse who has got the necessary qualification I think it is a natural progression for nurses in all different areas to be able to prescribe, especially the senior nurses. So I think it is quite fitting with the changing of nursing” (CS8 NNP)

“I think the nursing role has advanced, practice nursing itself is an advanced role, and I think nurse prescribing is a basic essential, certainly within the way I particularly work in this practice, and we are concentrating on chronic disease management and so on, it is an absolute natural thing to do. I think the way it has advanced or the way it could be perceived as being advanced is that you are reaching these decisions by using all those consultation skills that you may not have had the chance to learn and understand and develop in just the nursing”. (CS3 NP).

All nurses (apart from one) worked in a setting with multiple prescribers. For those working in general practice, the view was that nurses needed to acquire specialist knowledge and skills by completing disease specific modules before they undertook the prescribing course:

“They have all got some interest in it and understanding that they will do it at some stage but I think everybody recognises that you have got to get the ground work in first on the areas of specialism so you have got your minor injury, you have got the diabetes, you have got the asthma. Because you can’t really prescribe in those areas if you haven’t done the ground work. So at the moment we are concentrating, we have got one nurse doing her diabetic course at Warwick; we have just had two go through

the asthma and chronic obstructive pulmonary disease, I think everybody has now done minor injury and so on”(CS3 NP).

When asked if they felt under any pressure to undertake the prescribing course, the two NNPs based in general practice reported no pressure:

“None whatsoever, from the GPs or colleagues, they have viewed it as very much a personal thing and because I have specialist interests in other things as well as the diabetes, for example wound care, leg ulcer management and that sort of thing, they are letting me do the sorts of things I want to do, but I know if I wanted to do that I could ask at appraisal and I would be allowed to” (CS8 NNP)

In contrast, the non-prescribing DSN felt that there was pressure on nurses working at specialist level to undertake the prescribing qualification:

“I think there is a lot of pressure on all the specialist nurses at the moment. You feel quite, not necessarily undervalued, but I suppose you feel like you have to do it to move on ...” (CS7 NNP)

Course content

Nurses reported that the prescribing course provided students with both generic and specialist prescribing information. Not all aspects of the course were relevant to the areas in which nurses subsequently prescribed. However they found this information valuable:

“The nurse prescribing course has itself been quite useful up to a point, but as a nurse specialist it probably wasn’t ideally suited to a specialized sort of role, it was much more generic” (CS4 NP)

“It was comprehensive (the course) in all aspects of prescribing not just the individual specialities, it covered things that I wouldn’t normally do in practice, for instance pain relief, minor injuries, the areas that I don’t normally specialise in. But it was all covered, and I think that was actually extremely valuable and I think it highlighted other areas. Sometimes that will feed into my prescribing because I now have some awareness. It won’t necessarily make me actually write the prescription for that patient” (CS3 NP).

Some nurses had taken the course a number of years previously and there was a recognition that the course structure and content had since changed. Doctors and 1 NNP reported that there appeared to be variation across prescribing programmes with regards to the level of work required of students and the way in which courses were run in different universities. This is illustrated in the following quotes:

“I think the courses appear to have become more difficult as time goes on, that is the feedback I get from colleagues who’ve kind of gone through it. You know the first colleague who went through it compared to the most recent colleague, there is a very big difference in the level of work that is required for it” (CS7 NNP)

“The nurses who did it through X seemed to have a much easier route through to get their certificate at the end, and it was done in a helpful way, Whereas the course in Y seemed to be terrible in that the people on that course weren’t given very clear instructions of what was expected of them. They were expected to do tons of reading up and hours and hours as if they had no other work to do. It was demoralising for a lot of them. There was a very high failure rate and they were never quite sure of the parameters they were being checked on”. (CS6 Dr)

Mentoring role

Most nurses reported that doctors were very supportive in their role as DMP during the prescribing programme (although one nurse reported problems with obtaining access to the DMP).

“I talked to them [doctors about nurse prescribing] said that I hoped to do it and what I envisioned it would help me do etc. Then I got on the course and the senior partner was my mentor so I went to him and of course I spent quite a lot of time with him. He was excellent; he came to the university for all the meetings. I wasn’t aware of any opposition to it or difficulties at all”. (CS9 NP)

“I suppose the team that I work with have been very supportive. The consultant was very pro active in supporting us with prescribing and was my mentor for the course”. (CS4 NP)

The majority (8/9) of doctors were happy with the idea that nurse prescribers could play a role in mentoring nurses through the prescribing programme and thought nurses would benefit from the experience of others who have undertaken the course. The majority were also of the opinion that doctors continue to be involved in mentorship because of the depth and breadth of knowledge they hold, the necessity for maintaining standards and the complexity of prescribing in diabetes. This is expressed in the following quotes:

“I think that (nurse prescribers mentoring students) would be very useful because they will have been through it so they will know the questions, quandaries and dilemmas. I don’t think it should just be nurse prescribers that are doing it but I think they would have a very valuable role in using their experience, how they learnt and what the problems were. I would be in favour of that” (CS8 Dr).

“I don’t see why they [nurses] shouldn’t. It makes sense to have people who have actually done the course and know exactly what they are talking about to know what the expectations are in terms of standards and all the rest of it.” (CS4 Dr)

“I think so yes (expect a doctor to act as mentor), mainly because of the breadth of knowledge and complexity of some of the areas really. Having said that I would not have a problem with our nurse specialists now mentoring other nurses into the same role (CS 7 Dr).

DISCUSSION

The collective case-study approach adopted in this study did not seek to enable statistical generalisation of findings. The views about the prescribing programme presented are those of nurse prescribers, doctors, and NNP involved in the care of people with diabetes. They are not representative of health professionals in general.

Nurses in our study were of the opinion that over recent years the role of the nurse had changed. Nurses were adopting more advanced roles and new ways of working which required them increasingly to work autonomously. Prescribing was seen as a natural extension of these advanced roles which enabled and supported new ways of working. Nurses working in general practice reported that they did not experience any pressure to undertake prescribing training. These nurses had a range of interests in other specialist areas as well as diabetes and it was recognised that before they could become prescribers, there was a need to acquire specialist knowledge and skills through additional specialist modules.

GPs were said to be supportive of prescribing training, however, the decision to become a prescriber, was very much a matter of personal choice for the nurse. This was in contrast to the diabetes specialist nurse who reported that the prescribing qualification was seen as a necessary qualification for career progression and therefore there was a lot of pressure for them to prescribe. It is evident that DSNs are taking on advanced roles which are increasingly involving medicines management (James et al 2009). With the development of advanced nursing roles in diabetes, it may be that prescribing is becoming an essential requirement of the DSN role. This may account for the pressure experienced by the DSN in our study to undertake the prescribing programme.

Nurses in our study reported that the prescribing course provided students with generic prescribing information and covered therapy areas (such as minor illnesses and minor injuries) outside of their specialist area of practice. A lack of specialist content has been reported previously (Cooper et al 2008, Ryan-Woolley 2007, Goswell & Siefer 2009, Courtenay & Carey 2008). Of the 1575 Macmillan nurses surveyed by Ryan-Woolley (2007) 30% of the 70 prescribers in the sample reported that they had concerns around the lack of relevance of the prescribing course to cancer and palliative care. Similarly, 50% of the 439 nurses (who prescribed for people with diabetes) surveyed by Courtenay & Carey (2008) reported that the prescribing programme and the 12 days medical practice support did not meet their needs with respect to diabetes. However, these findings are in contrast to nurse prescribers in our study who reported that this generic prescribing information was extremely valuable with regards to the medical management of this group.

Doctors and NNP reported that prescribing programmes varied. Clinical specialist knowledge and variations between courses has recently been reported by Cooper et al (2008). However, the variations raised by participants in our study appeared to be related to the amount of study hours required of students, and the support provided with regards to the clarity of parameters within which students were assessed. In addition, it was also highlighted by NNPs in our study that the expectations of more recent cohorts of prescribing students seemed to be higher than for those undertaking earlier courses. A possible explanation for this is that since the inception of the prescribing programme, many universities and HEIs have incorporated the prescribing module into post qualify pathways such as the nurse practitioner course. In some instances, the number of academic credits awarded has increased and, are available at masters level. Such an increase would account for the rise in expectations of students. This is something that nurses should consider prior to undertaking the prescribing course.

Nurses in our study largely reported that doctors were very supportive in their role as mentor during the prescribing programme. This is in contrast to Cooper et al (2008) and Ryan-woolley et al (2007) who reported inadequacies around the DMP role. Although doctors in our study believed that they should continue to be involved in mentorship because of their breadth and depth of knowledge and the complexities surrounding prescribing in diabetes, the majority were of the opinion that it would be beneficial if nurse prescribers were to play a role in mentoring nurses through the prescribing course.

CONCLUSION

Prescribing supports advanced nursing practice. Nurses considering undertaking the prescribing course need to be aware of the variations across prescribing programmes with regards to the level of work required. There is support for joint mentorship between nurse prescribers and doctors for students undertaking taking the prescribing course

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Table 1: Data collected from each case site

Case Site	Job Title	Setting	Number of nurses	Interviews		
				Nurse prescriber	Doctor	Non-nurse prescriber
1	NP	GP	1	1	1	0
2	DSN	HP	1	1	1	0
3	PN	GP	1	1	1	0
4	DSN	CC	1	1	1	0
5	NP	GP	1	1	1	0
6	NP	GP	2	2	1	1
7	DSN	HP	1	1	1	1
8	PN	GP	1	1	1	1
9	DSN	CC	1	1	1	0
Total		10	10	10	9	3

Code NP=Nurse Practitioner, PN=Practice Nurse, Diabetes Specialist Nurse = DSN, GP = General Practice, Hospital = HP, Community Clinic = CC