Stakeholder views on the impact of nurse prescribing on dermatology services.

Nicola Carey, MPH, BSc (Hons), RN: Senior Research Fellow, University of Reading,

Karen Stenner BSc (Hons): Research Fellow, School of Health and Social Care, University of Reading

Molly Courtenay, MSc, PhD, RN: Professor of Prescribing and Medicines Management, University of Reading.

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Address for correspondence: School of Health and Social Care, University of Reading, RG6 1HY. UK. email: n.j.carey@reading.ac.uk

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Author Contributions

Background NC

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MC obtained funding and supervised study

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ABSTRACT

Aim

The aim was to explore stakeholder views on the impact of nurse prescribing on dermatology services.

Background

Nurse led care enhances the services that dermatology patients receive. Research indicates that care delivered by nurse prescribers can improve efficiency and access to medicines. There is no evidence exploring the impact of nurse prescribing on the configuration of dermatology services

Method

A collective case study of 10 practice settings across England in which nurses prescribed medicines for dermatology patients. A thematic analysis of semi-structured interview data collected during 2006 and 2007. Participants were qualified nurse prescribers, administrative staff, doctors and non-nurse prescribers.

Findings

Nurse prescribing was reported to support and facilitate the modernisation of dermatology services. It enabled nurses to make effective use of their knowledge and skills, overcome delays in treatment and provide faster access to medicines. However a number of organizational issues restricted the success of the initiative.

Conclusion

Nurse prescribing is successfully being used to support and deliver a range of services to dermatology patients. Stakeholders reported that both patients and staff had benefited by the adoption of this role by nurses. However issues over support and access to CPD, and capacity of the workforce were identified as potential barriers which could affect the contribution of nurse prescribing to dermatology patients.

IMPLICATIONS FOR CLINICAL PRACTICE

- Nurse prescribing contributes to the services provided to dermatology patients
- Nurse supplementary prescribing contributes to the ability of dermatology nurse specialists to work in teams and prescribe complex medicines
- Provision of adequate support and strategic planning are essential if the impact of nurse prescribing is to be fully realised

Key words: nurse prescribing, dermatology, services

INTRODUCTION

Skin disease affects 22-33% of the population, and the prevalence of common skin conditions, e.g. leg ulcers, skin cancer and atopic eczema is increasing (Department of Health (DoH) 2007). Large numbers of people with mild forms of skin disease manage their own condition however, it is estimated that skin disease is the fourth commonest reason for a GP consultation, including 5% of cases which are subsequently referred to secondary care (DoH 2007).

Until recently most skin conditions have been managed either by general practitioners (GP) or in secondary care by specialist dermatologists (British Association of Dermatologists & Royal College of Physicians 2008). However, although, the provision of services which are both flexible and accessible to patients, is a key priority of recent government policy in the United Kingdom (UK) (DoH 1999, DoH 2000, DoH 2007), the demand on appointments in general practice and a shortage of dermatologists (Associate Parliamentary Group on Skin (APGS) 2002) means that doctors are now increasingly unable to meet the service demands of the high number of patients with these conditions. It is recognized that nurses have lead roles to play in the delivery of dermatology services (Courtenay & Carey 2006, DoH 2007), and that nurse prescribing is an important component of the services that they provide (DoH 2007).

Following a series of legislative changes between 1992 and 2006, nurses in the UK now enjoy extended prescribing rights, and virtually have the same prescribing rights as doctors (DoH 2006). Appropriately qualified nurses are able to undertake training enabling them to prescribe both as independent and supplementary prescribers. Nurse

Independent Prescribing (NIP) and Nurse Supplementary Prescribing (NSP) are two different modes of prescribing training for which is combined. Upon successful completion of the programme, nurses are able to use both independent and supplementary prescribing. NIPs are able to prescribe any licensed medicine (and some controlled drugs (CDs)) provided that it is within their area of competence (DoH 2006). Whilst any medicine (including unlicensed medicines and CDs) can similarly be prescribed by qualified NSPs (DoH 2003), this only takes place after assessment and diagnosis of the patients condition has been made by a doctor, and a Clinical Management Plan (CMP) (which includes a list of medicines from which the NSP is competent to prescribe) has been agreed between the nurse, doctor and patient. There are currently over 13,000 qualified NIP/NSPs across the UK (Nursing and Midwifery Council (NMC 2007)).

Recent evidence suggests that nurses are frequently prescribing for skin conditions (Latter *et al.* 2005, Courtenay *et al.* 2007, Carey *et al.* 2007). 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. The majority of these nurses are in primary care and prescribe between 6-10 items a week. Conditions for which they commonly prescribe include eczema, fungal infections, impetigo, acne, and psoriasis (Courtenay *et al.* 2007, Carey *et al.* 2007). However, there is no evidence exploring the impact of nurse prescribing on dermatology services.

BACKGROUND

A review of the literature suggests that nurse-led care in the UK enhances the services that patients with dermatology conditions receive (Courtenay & Carey 2006). Cox and Walton (1998) in a review of medicines administered and supplied by nurses in a dermatology department, distributed a questionnaire to 45 adult patients. In addition to improving access to treatment, the findings indicated that nurse-led care enabled patients to receive care from an expert, eliminating or deferring the need for a separate appointment with a GP or dermatologist. More recently, and in support of these findings, McEvoy (2004) reports on patient evaluations of a nurse-led dermatology advice clinic within the primary care setting. Information collected from patient questionnaires identified that less than 10% of patients were referred from the clinic to see a consultant dermatologist.

Although not looking at the configuration of dermatology services, one study has specifically explored how nurse prescribing contributes to the delivery of services to patients (Carey & Courtenay 2007). In this survey of 439 NIP/NSPs, who prescribed for patients with diabetes, nurses worked in a variety of roles (i.e. nurse practitioners, specialist nurses and community matrons) and provided a range of services in both primary and secondary care. Over 90% of patients were based in the community, and more than 70% of participants used nurse prescribing to support services delivered in general practice.

A number of studies based in the UK have also reported on the benefits of nurse prescribing. It is evident from this literature that both doctors and nurses believe nurse prescribing improves access to healthcare (Avery *et al.* 2004, Bradley *et al.* 2005,

Bradley & Nolan 2007, Courtenay & Berry 2007, Nolan & Bradley 2007, Ryan-Woolley *et al.* 2007). For example, Avery *et al.* (2004), conducted interviews with six hospital doctors and six general practitioners in varied settings in one region in the UK, and reported that the main perceived benefits for patients were improved efficiency and fewer delays in waiting for prescriptions to be signed. Additionally, Bradley & Nolan (2007), interviewed 45 qualified nurse prescribers, and reported ease of access to medication, increased availability of the nurse, and continuity of care were some of the benefits of independent and supplementary prescribing.

Although the evidence is generally positive, concerns have been raised surrounding the provision of support, access to continuing professional development (CPD) (Humphries & Green 2000, Otway 2001, Bradley *et al.* 2007, Carey *et al.* 2007), and the extra demands prescribing creates by increasing nurses workload with little capacity to delegate (Bradley & Nolan 2007, Nolan & Bradley 2007, Ryan-Woolley *et al.* 2007).

There is no evidence available which that explores stakeholders views on the effect that nurse prescribing has on the services that patients with dermatology conditions receive. This is important given the increasing number of patients with skin conditions and the high number of nurses who prescribe for them.

THE STUDY

Aim

The aim was to explore stakeholder views on the impact of nurse prescribing on dermatology services.

METHODOLOGY

This paper reports on a set of interview data from a larger study, the aim of which was to explore the treatment management of patients with dermatological conditions by NIPs/NSPs. A national survey of NIPs/NSPs, who prescribed medicines for dermatology patients was conducted to address the initial phase of this research, the findings of which have been reported previously (Courtenay *et al.* 2007, Carey *et al.* 2007, Courtenay *et al.* 2006).

The second phase of the research adopted a collective case study approach (Stake 1995), multiple methods of data collection (i.e. interviews, questionnaires, video consultations and prescriptions) were used to capture a range of perspectives. Data collected from the national survey were used to select case studies (n=10) of practice settings in which nurses prescribed medicines for dermatology patients. This paper reports on interview data collected from nurse prescribers, administrative staff, doctors and non-nurse prescribers. Additional findings from phase 2 of the research (including questionnaires, video consultations and prescriptions) are reported elsewhere (Courtenay *et al.* 2008).

Participants

A number of criteria which emerged from the findings of the survey were used to purposively select cases in different geographical locations in England, and represent dermatology services provided in primary and secondary care. Case studies included Dermatology Specialist Nurses (n=4) and a Dermatology Nurse Consultant working across both primary and secondary care. Practice Nurses (n=3) (two practice nurses worked in one site) and Nurse Practitioners (n=2) working in primary care (see Table 1). Within each case study site data was collected from a purposive sample of doctors, who supervised or supported a nurse prescriber, administrative staff and non-prescribing nurses who worked alongside the nurse prescriber.

DATA COLLECTION

Case study data collection took place between June 2006 and September 2007. A total of 40 semi-structured interviews were conducted with nurse prescribers and members of the healthcare team (i.e. doctors, administrative staff and non-prescribing nurses). The face to face interviews were held in mutually convenient locations at the case study sites. Interviews lasted between 10-40 minutes and all participants gave permission for the interviews to be audio-taped and transcribed. All interviews were conducted by a researcher from the University of Reading.

The interview schedule was informed by a literature review (Courtenay & Carey 2006) and findings from a national survey exploring nurse prescribing in dermatology (Courtenay *et al.* 2006). The interview schedule covered general views and

experiences of NIP and NSP for dermatology patients, role changes resulting from prescribing, difficulties arising from prescribing, support and supervision.

Ethical considerations

Approval to undertake study was granted by the National Health Service (NHS) research ethics committee and the local relevant Primary Care Trust (PCT) or hospital trust.

Participants in the national survey who indicated that they may be interested in participating in phase 2 of the research, and met the sampling criteria were initially approached. Once an interest and managerial support were confirmed, participants were given an introductory letter and the project protocol. Other members of the healthcare team were also approached and asked to participate in an interview. A researcher then arranged dates, and prior to the interview participants had the opportunity to ask any questions. Participants were informed that all responses would be anonymised.

DATA ANALYSIS

A thematic analysis, a recognised method used to identify, analyse, and report themes and patterns within interview data, was conducted (Braun & Clark 2006). ATLAS.ti, a qualitative data analysis software package, was used to aid initial coding and identification of patterns across the data. This was followed by further discussion and interpretation between two researchers (NC & KS) to identify areas of data convergence and overall interpretation of themes. Saturation of the data was achieved. Once themes were developed the data was analysed by type of health care

professional, and setting (i.e. specialist versus nurses in general practice), to identify any differences.

Rigour

For the purposes of this paper data from nurse prescribers, administrative staff, doctors and non-nurse prescribers were selected as a unit of analysis. The comprehensiveness of the findings was enhanced by triangulation of data sources to elicit the various and divergent views from each group of health care professionals. Two skilled qualitative researchers independently assessed the transcripts and enhanced reliability of the findings. Minor differences in assessment were consolidated through discussion. Interim findings were presented at a nurse prescribing conference held at the University of Reading and the British Dermatology Nursing Group (BDNG) nurse prescribing sub-committee, delegates and members of whom were involved in data collection at case study sites.

FINDINGS

Across the 10 case study sites 40 interviews were conducted including nurse prescribers (n=11), doctors (n=12), administrative staff (n=11) and non-nurse prescribers (n=6) (see Table 1). However, a problem with audio equipment with a practice nurse meant only 39 interviews were transcribed and analysed.

Nurses working in general practice (nurse practitioners and practice nurses) predominantly dealt with minor skin conditions and patients requiring one-off treatments (e.g. fungal infections & impetigo). By contrast, specialist nurses generally treated patients with chronic skin conditions who required long-term care (e.g. eczema, psoriasis & acne).

The analysis resulted in two themes relating to the contribution of nurse prescribing to the delivery of dermatological services: modernising health services and organizational issues. The two themes (each with a number of sub-themes) were distinct and demonstrated that participants identified a number of areas where nurse prescribing had enhanced the provision of dermatology services. However, participants reported a number of organizational issues which ultimately restricted the success of the initiative.

Quotations are used to illustrate themes in the analysis. To protect anonymity of participants, references to names or places have been removed from these quotations. Names have been replaced by an 'x' where appropriate. Quotations are followed by a code referring to the case study site number (cs) and the participant group of the person quoted. Participant groups have been abbreviated to Dr=doctor, NP = nurse prescriber, NNP =non prescribing nurse, AS=administrative or reception staff.

A. MODERNISING SERVICES

Faster and more efficient service

The most immediately apparent benefit of nurse prescribing reported was the improved speed and efficiency of access to medication and services for patients. In general practice (GP), changes to appointment systems had predominantly been influenced by the introduction of Advanced Access (an approach to booking appointments which ensures patients have access within 48 hours (DoH 2000)), and nurse led minor illness clinics. For patients who attended the hospital/ specialist community clinic, waiting list times had been reduced by the introduction of nurse-led

clinics. The capacity to prescribe was reported to be integral to the success of the nurse led initiatives:

I think there is a definite advantage for the patient because they would be seen earlier than if they had to wait to go onto the doctors list because the waiting list would be longer. (cs3AS1)

Participants frequently reported how services were dependent upon nurse prescribing. This was particularly evident in the dermatology clinics. Doctors, both specialists and general practitioners, reported that historically clinics had always been overbooked. In the cases where nurse-led clinics had been introduced, there simply was no capacity for these services to be managed by a doctor:

When I have a patient that I know can be followed up by a Nurse Practitioner I am thrilled because I have got no room in my follow-up clinics. So what I have actually done is become dependent. I mean if the Nurse Practitioner in this department was withdrawn I would not be able to look after the patients under my care. (cs3Dr1)

Improved Access

Participants reported how nurse prescribing had effectively increased the number of ways a patient could receive their care. The ability to prescribe combined with the increased availability of appointments and wider range of clinic settings was reported by AS, across the case study sites, to have effectively increased patient choice with

respect to times of appointments and in deciding which health care professional to consult:

Because they can see X [nurse prescriber] they do see 'X', you know, to get a course of antibiotics or some cream or whatever. They will see X and come in and see her for whatever reason. (cs7AS)

Nurses were also praised for their approachability and ability to build rapport with patients:

some patients find it less daunting to chat to a member of nursing staff than a doctor because, even though I'm quite approachable when I am actually seeing a patient I am usually in a room with two medical students, with SHO's [senior house officer] and Registrars coming in and out, and the quality of environment is lost in that sense. (cs3Dr1)

AS in general practice reported that in some instances patients preferred to see the nurse (all female) particularly if they perceived the problem to be minor or sensitive in nature. Commenting on patients in general, rather than those only with a skin complaint, they additionally reported that most appeared to have accepted, that for same day appointments, it was likely that a nurse would deal with their problem:

I think the patients sometimes don't mind going to the nurse rather than going to the doctor sometimes. They are quite happy to see if the x [nurse prescriber] can deal with it. They don't want to 'bother the doctor with something like that'. (cs2AS1)

Skill mix and flexible working

Nurse prescribing was reported to support skill mix and facilitate different ways of team working. Participants reported a mixed impact on the individual workloads of team members. Some doctors reported that the content of their workload had changed. For example, GPs reported that they now saw more complex patients (although not those with dermatology problems) and fewer patients with minor illness (including those with skin conditions). In addition to an increased remit of new patients, another dermatology doctor similarly reported that they also saw more complex patients:

It has changed the nature of our work. X see's a lot of her own patients in follow ups, which obviously creates more space, it is about properly using skills. Therefore I am more available for using my diagnostic skills in new patients as a result. (cs10Dr1)

The main impact of nurse prescribing reported by all doctors was less interruptions and less signing of prescriptions for patients they had not fully assessed:

Previously she would come and say this is what they need and I would just sign at the bottom, so it makes much more sense if I am not seeing the patient for her to be signing the prescriptions. (cs1Dr)

There were examples where changes to the structure of the team had occurred, such as the introduction of Health Care Assistants:

If they [nurse prescribers] are doing more extended roles then somebody else must be doing them [more traditional tasks]. I think there has been a push of those tasks down the hierarchy to health care assistants. (cs3Dr1)

Additionally one AS, who also worked in the GP out of hours services, commented on a reduction in the number of doctors:

We used to have more doctors and now we have less doctors, because we have more nurse prescribers, so it does make a difference to the team. The nurse practitioner stands in place of the GP now. (cs1AS)

Nurse prescribing was thought by doctors and AS to support more efficient team working because of the speed and convenience of having a nurse prescriber at hand. In this respect, work life was made easier for team members by the additional capacity offered by nurse prescribing:

Actually the nurses can't do it all and the doctors can't do it all, so actually you need a team and that is what we have developed here. (cs9Dr3)

Nurse Supplementary Prescribing

In each of the specialist dermatology units NSP was used in the management of systemic treatments for patients with acne and psoriasis. Although the process of getting CMPs approved through hospital committees was reported to be time consuming, NSP was reported to provide an ideal mechanism to support a consistent

approach to care if the nurse involved in the clinic changed. It also enabled nurses to continue treating patients who required systemic therapy for the management of their condition:

Most of our nurses use Clinical Management Plans. The reason for that is because it makes it easier for people in the future who follow them to fit into the protocol that we have got. (cs3Dr1)

B. ORGANIZATIONAL ISSUES

Ceiling effect

There was some evidence of a ceiling effect whereby once nurse prescribers were working to capacity, no more benefits could accrue unless more resources were put in place. For example, one specialist nurse avoided prescribing complex medications or taking on high-risk patients because of the inability to take on the extra workload this entailed:

Many of the drugs would have to be on a clinical management plan, as they are off license for children. I might review the child in between their consultation with the consultant, but they will have the [treatment] package in place, and purely I do not have enough clinical time in my life to fit it all in. (cs10NP)

Lack of cover for nurse-led clinics, for both specialist and GP nurses, during absences was highlighted as a problem by nurses and administrators. When this occurred, the benefits of nurse prescribing were lost as work patterns reverted to less efficient, old ways of working:

At the moment we only have one [nurse prescriber] so it makes it impossible if X is off sick for another nurse to do her clinic without a lot of stress for the other person. And also time consuming for the patients because that nurse might have all the knowledge and skills but they will have to get the doctor to come in because they have not done the prescribing course. (cs3NNP)

Local restrictions

Whilst nurse prescribing appeared to be firmly embedded in to service provision, several examples were given where organisational restrictions (within the hospital outpatient setting) had inhibited prescribing practice. Five nurses (4 specialists) had experienced some sort of local restriction on their prescribing. Two of these were local formulary restrictions on prescribing of emollients and in both cases the nurse was actively involved in revoking the restriction. One nurse was restricted to using hospital only prescriptions and two nurses had experienced procedural delays in getting approval to prescribe certain drugs:

What has made prescribing difficult is the frustration because I run an X clinic and I should be able to prescribe Y in a Clinical Management Plan, but we have had an extremely long wait here from our Prescribing Lead to approve them. Although we designed them, prepared them and they were ratified by our Consultants and then the Pharmacist. The process has taken about six months, and in that time I have seen so many patients on Y that I could have prescribed for. (cs8NP)

With regard to the formulary it has been difficult to get hold of the full formulary from the hospital, but we have been able to use pressure to get that. [] because I've prescribed I have actually influenced the emollient formulary in a much more patient friendly way by patient choices. So it's been positive in that way really. (cs3NP)

Continued Professional Development and Support

A range of support mechanisms were used by nurse prescribers including individual support from clinicians and peers, feedback and advice from non-medical prescribing groups, specialist networks and information from internet services, journals and conferences. Managers, particularly those supporting specialist nurses, were praised for their flexibility in allowing nurses time to develop the prescribing role. Pharmacists were noted as a source of information and advice and for their role in querying prescriptions.

Nurse prescribers reported that access to CPD varied and there was a lack of training specific to dermatology. In addition to providing greater support for nurses working in the community, more guidance was requested on dermatology training:

Ongoing support has gone very hit and miss. In the first year there were a few evening sessions on general stuff, not specific to dermatology. Now with all the reorganisation it has completely hit the bin and you don't get any CPD from the employer. (cs1NP)

Monitoring and feedback

It was important to nurses to have a means to discuss and confirm the appropriateness of their assessment and prescribing decisions, especially early on in their prescribing career when confidence was lacking. For example, one specialist nurse requested more structured support from clinicians early on in the prescribing role and another wanted measures to check that patterns of prescribing were evidence-based rather than due to habit:

One of our registrars is going to set up teaching sessions for us, going through blood results specifically, but I think all this kind of thing could have been done at the start, with a much more multi-disciplined approach to it rather than ‘right, you can prescribe, let’s start up the clinics for you (cs10NP)

Formal support in the way of clinical supervision varied. Although nurses felt they could access a doctor if they needed; only 3 nurses had regular clinical supervision sessions. A greater number of the specialist nurses had formal prescribing support meetings in place. For others, (including both GP and some specialist nurses) such support had once existed but had stopped, or was currently being planned but was not yet in place.

Formal feedback from Prescribing Analysis & Cost (PACT) data, audit or other clinical governance procedure was also slow to develop. Whereas some nurses had just started to receive information on their prescribing patterns, others resorted to keeping records of their own prescribing practice because they were not receiving any

data on this. Others were aware that their prescribing decisions were being audited but having had no feedback on this, assumed that no problems had arisen:

I don't get the PACT data. All they [prescription pricing authority] can do is to provide data based on the post code. So I can get it for what the doctor and I both prescribe, but I can't get it for me. That's why I keep a copy of what I prescribe. (cs1NP)

DISCUSSION

This study is the first to specifically report on the impact of nurse prescribing on the configuration of dermatology services, and represent stakeholder views from a range of practice settings.

Our findings suggest that nurse prescribing enabled nurses to make more effective use of their knowledge and skills, overcome delays in treatment and provide faster access to medications. Nurses were less dependent upon doctors, and doctors were no longer asked to sign prescriptions for patients they had not assessed. Nurses and doctors were able to work more efficiently which was felt to enhance the quality of care and services provided. These findings support the aims of recent UK government policy (DoH 1999, DoH 2000, DoH 2006), and reiterate the contribution that nurse prescribing can make to the delivery of dermatology services (Carey & Courtenay 2006, DoH 2007).

In this study, improvements to services were considered particularly important as it is recognised that doctors are increasingly unable to meet the demands of dermatology

patients (APGS 2002, DoH 2007). Nurse prescribing effectively increased the number of appointments where patients could receive care, and their medication, in a more timely fashion. Furthermore, there was evidence that these services were now dependent upon the capacity of the nurse to prescribe medicines. In general practice, (where nurses predominantly dealt with minor skin conditions), this was primarily achieved by the capacity of nurses to prescribe medicines in the already established minor illness clinics. By contrast the affect on the configuration of services offered by specialist nurses (the majority of whom tended to deal with chronic skin conditions) was more dramatic. For example, NSP provided an ideal mechanism for nurses to work in teams and manage patients who required more complex medications. In addition, the ability to prescribe as an NIP also supported more effective skill mix and flexible working. Nurses were able to work independently, without the presence of a medical prescriber, and as a result new clinics and nurse led services had been introduced in both dermatology out-patients and primary care. Realignment of doctor's workloads were reported as the number of patients that consulted GPs for a skin condition reduced, and specialist dermatology doctors increasingly saw patients with more complex skin conditions. These findings provide some insight into the contribution that nurses who have the capacity to prescriber can make to UK dermatology services. They also support findings recently reported by Carey & Courtenay (2007) who identified that over 70% of nurses who prescribed for patients with diabetes used their ability to prescribe to support services delivered in general practice.

The fact that NSP was used to prescribe complex medicines by specialist nurses (who had extensive knowledge and skills in this area), provides some evidence that

supplementary prescribing is a useful mechanism to treat patients with complex conditions, where a team approach to care is necessary.

Nurse prescribers reported that they made use of variety of resources for support and development. Participants accessed support from clinicians and peers, non-medical prescribing groups, specialist networks, information from journals and conferences, a need for more relevant dermatology courses, which included information on polypharmacy, drug interactions, and interpreting blood tests was also expressed. Access and availability to support and CPD for the prescribing role however, were inconsistent across the case study sites. Whilst this is in contrast to recent government guidelines (DoH 2006), which stipulate that the employer should ensure that the practitioner has access to relevant ongoing education and training provision, inadequacies in the provision of support, feedback, audit and CPD have been previously reported in the literature (Humphries & Green 2000, Otway 2001, Latter *et al.* 2005, Courtenay *et al.* 2007, Courtenay *et al.* 2006). This is important as a lack of specialist knowledge, support and poor access to CPD, have been reported to affect the frequency with which nurses prescribe (Otway 2001, Latter *et al.* 2005, Carey *et al.* 2007). In order that nurses can continue to develop confidence and competence in their prescribing role, it is evident that the provision of appropriate dermatology courses, access to CPD and formal feedback are areas that need to be developed by education providers, and more formally embraced by managers within each organisation.

The success of the prescribing initiative, particularly for specialist nurses, was affected by a lack of capacity to undertake more work or develop services further. The

issue of capacity and how it can restrict practice has previously been reported in the literature (Nolan & Bradley 2007, Bradley & Nolan 2007). Lack of capacity in this context was due increasing workloads prescribing created and the small number of nurse prescribers in each case study site. Whilst there are obvious difficulties in funding health care, if the full potential of nurse prescribing is to be realised the wider implications of supporting the prescribing role need to be considered by those involved with the strategic planning and organisation of services.

Limitations

This was a self-reporting study of stakeholders who worked with nurses that provided services to patients with dermatology conditions. Their views are therefore likely to be biased towards supporting nurse prescribing. We also acknowledge that the study is limited to the views of stakeholders working in this clinical area. In order that the views of dermatology patients and the impact of nurse prescribing on service delivery can be evaluated using different research methodologies, further research is therefore required.

CONCLUSION

Nurse prescribing is successfully being used to support and deliver a range of services to dermatology patients. Stakeholders reported that both patients and staff had benefited by the adoption of this role by nurses. However issues over support and access to CPD, and capacity of the workforce were identified as potential barriers which could affect the contribution of nurse prescribing to dermatology patients.

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Table 1: Data collected from each case study site

Case Study	Job Title	Number of nurses	Interviews			
			Nurse prescriber	Doctor	Admin staff	Non-nurse prescriber
1	DSN:	1	1	1	1	X
2	PN	2	2	1	2	1
3	DSN	1	1	1	1	1
4	NP	1	1	1	1	X
5	NP	1	1	2	1	X
6	PN	1	1	1	1	1
7	PN	1	1	X	1	1
8	DSN	1	1	1	1	1
9	DNC	1	1	3	1	1
10	DSN	1	1	1	1	X
Total		11	11	12	11	6

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