

Evaluation of nurse and pharmacist independent prescribing

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1 Executive summary

1.1 Summary of Key Points

- Between 2% and 3% of both the nursing and pharmacist workforce are qualified to prescribe medicines independently
- 93% of nurse prescribers and 80% of pharmacist prescribers had used their independent prescribing qualification. 86% of the nurses and 71% of the pharmacists were currently prescribing¹
- Nurses and pharmacists are prescribing predominantly in primary care, with substantial numbers also in secondary care settings
- Study results indicate that overall, nurse and pharmacist prescribing is currently safe and clinically appropriate
- The study findings indicate that current educational programmes of preparation for nurse and pharmacist prescribing are operating largely satisfactorily, and provide fit-for-purpose preparation
- Evidence suggests that non-medical prescribing has been largely driven by individual practitioners to date, and has been used to increase the quality of existing services, as opposed to enabling service re-design
- Only about half of Trusts reported a strategy or written plan for the development of non-medical prescribing
- Key clinical governance and risk management strategies for non-medical prescribing are in place within the majority of Trusts
- Acceptability of independent prescribing to patients is high, as evidenced by the majority of patients reporting that they were very satisfied with their visit to their nurse or pharmacist prescriber
- When comparing care provided by their nurse or pharmacist independent prescriber to being treated by their GP, most patients in this study did not report a strong preference for either their non-medical or medical prescriber
- Results indicate that non-medical prescribing was generally viewed positively by other health care professionals
- Nurse and pharmacist independent prescribing in England is becoming a well-integrated and established means of managing a patient's condition and giving him/her access to medicines
- Key issues for further expansion of non-medical prescribing may include preparing nurses and pharmacists to prescribe across conditions for patients with co-morbidities

¹ The survey was conducted in autumn 2008 when there were 358 pharmacist independent prescribers who had been qualified for longer than 6 months, and all were surveyed. NB In July 2010, there were more than 1,100 qualified pharmacist independent prescribers.

1.2 Background

The original policy objectives for the development of non-medical prescribing from 2000 related to the principles set out in the NHS Plan (DH, 2000): improvements in patient care, choice and access, patient safety, better use of health professionals' skills and more flexible team working across the NHS. In working towards these objectives the NHS embarked on a graduated move to increase the scope and responsibilities of non-medical prescribing. This culminated in the opening of the British National Formulary (BNF) to independent nurse and pharmacist prescribers in 2006, and national policy guidance on implementation (DH, 2006). This study was commissioned in the wake of these policy changes to provide a national evaluation of nurse and pharmacist independent prescribing in England. The research was conducted between May 2008 and May 2010.

1.3 Study aims and objectives

The overall aim of the study was to evaluate nurse and pharmacist independent prescribing in order to inform planning for current and future prescribers.

The study addressed the following research questions, developed from the specified objectives:

1. What is the scope and scale of independent prescribing (IP) by nurses and pharmacists?
2. What is the quality of, how safe, and how clinically appropriate is IP by nurses and pharmacists?
3. Are the operational arrangements for clinical governance and risk management for IP by nurses and pharmacists adequate and sufficiently robust to ensure patient safety?
4. What are the prescribing models in current practice, their associated resources, and patient utility?
5. Is IP by nurses and pharmacists acceptable to patients, and what are patients' experiences of the impact of IP on choice, access, and clinical outcomes?
6. Do any changes need to be made to existing educational programmes for nurse and pharmacist independent prescribers?
7. What is the response of other health professionals to nurse and pharmacist IP?

1.4 Design and methods

The study design had three phases:

1.4.1 Phase 1: National overview

- National questionnaire survey of nurse and pharmacist independent prescribers
- Telephone survey of non-medical prescribing Trust leads
- Focus group discussions with Higher Education Institution non-medical prescribing programme leads and Designated Medical Practitioners
- Secondary analysis of national datasets on safety incidents

1.4.2 Phase 2: Case studies of practice

At each case site:

- Analysis of the clinical appropriateness of nurse and pharmacist independent prescriber consultations using the Medication Appropriateness Index
- Case record analysis of nurse and pharmacist independent prescriber consultations against national prescribing standards
- Patient surveys of experiences, outcomes and preferences
- Interviews with health care professionals

1.4.3 Phase 3: Multi-stakeholder workshop

- Stakeholders were invited to consider and prioritise the preliminary study findings and implications

1.5 Main findings

1.5.1 Scope, scale, and models of nurse and pharmacist independent prescribing

Upon qualifying, the majority of both nurse and pharmacist prescribers make use of their independent prescribing authority. 93% of nurse prescribers and 80% of pharmacist prescribers had used their independent prescribing qualification. 86% of the nurses and 71% of the pharmacists were currently prescribing. Independent prescribing is the main form of delivering medicines to patients after qualifying as a prescriber, but many also continue to use both Patient Group Directions and supplementary prescribing as part of their role.

Nurse, and to a lesser extent pharmacist, independent prescribing is becoming a widely integrated feature of health service delivery, with nurses qualified to prescribe in nearly all Trusts in England and pharmacists prescribing in an increasing number of Trusts. Approximately 2–3% of both the nursing and pharmacist workforce are qualified to prescribe medicines independently.

Nurses and pharmacists are prescribing predominantly in primary care, with substantial numbers also in secondary care settings. They prescribe for a range of conditions: nurses across a range of acute and long-term conditions associated with their roles, pharmacists predominantly for cardiovascular and a number of other long-term conditions. Key issues for further expansion of non-medical prescribing may include preparing nurses and pharmacists to prescribe across conditions for patients with co-morbidities, and consideration given to pharmacists prescribing for a wider range of conditions.

Prescribing volume indicates a regular contribution by nurses and pharmacists to the prescription of medicines for patients.

The evidence suggests that non-medical prescribing has been largely driven by individual practitioners to date, and has been used to increase the quality of existing services, as opposed to enabling service re-design. Only approximately half of Trusts reported a strategy or written plan for the development of non-medical prescribing. If workforce planning is to be effective, more Trusts need to develop their strategic approach for non-medical prescribing.

1.5.2 Safety, clinical appropriateness, and quality of nurse and pharmacist independent prescribing

Study results indicate that nurse and pharmacist prescribing is currently safe and clinically appropriate. There was some indication that assessment and diagnostic skills associated with prescribing could be improved, and some medicines prescribed may not be the most cost effective and / or consistent with national guidelines on prescribing.

Most nurses and pharmacists generally reported communicating with patients about medicines in line with national guidelines, discussing issues likely to facilitate effective patient medicine-taking, although discussing concerns, misunderstandings and side effects of medicines were reported more frequently than discussion of patients' beliefs about medicines and their necessity. This latter finding may warrant consideration by Higher Education Institutions delivering non-medical prescribing education and training programmes. Most patients of both nurse and pharmacist independent prescribers said they had been told as much about their medicines as they wanted, that they were involved in decisions about the medicines prescribed, and that they felt the prescriber understood their point of view.

1.5.3 Clinical governance and risk management of nurse and pharmacist independent prescribing

Clinical governance and risk management strategies for non-medical prescribing are in place within the majority of Trusts. Most nurse and pharmacist independent prescribers also report using a range of quality assurance tools and continuing professional development activities in their practice, and have on-going support from an experienced prescriber. However, systems for dealing with poor performance of NMPs were more frequently reported for secondary than primary care Trusts and most Trusts do not have a system to cover services provided by non-medical prescribers when they are absent. In addition, patient feedback strategies were not used by the majority of Trusts.

Stakeholder workshop participants recommended greater public and patient involvement in non-medical

prescribing, a common quality assurance framework for all prescribers – inclusive of nurses, pharmacists, doctors and other allied health professionals – as well as more planning and support for newly qualified non-medical prescribers.

These and other strategies will require consideration as priorities for implementation, as mechanisms to ensure safety and quality of current forms of non-medical prescribing, and as further changes enabling prescribing of unlicensed medicines and controlled drugs come into force.

1.5.4 Patients' views of nurse and pharmacist independent prescribing

Acceptability of independent prescribing to patients is high as evidenced by the majority of patients reporting they were very satisfied with their visit to their nurse or pharmacist prescriber and overall they felt they had a good relationship with and confidence in the independent prescriber. The findings of our Discrete Choice Experiment also showed that patients valued pharmacist and nurse prescribing services as an alternative to GP prescribing in primary care.

When comparing care provided by their nurse or pharmacist independent prescriber to being treated by their GP, most patients in this study did not report a strong preference for either their non-medical or medical prescriber. Findings from our Discrete Choice Experiment are congruent in that respondents consulting for an exemplar long-term condition equally preferred a prescribing service provided by their own doctor or a prescribing pharmacist. Consulting a nurse independent prescriber was preferred over the option of doing nothing for a headache and fever; the family doctor was found to be the preferred choice over a prescribing nurse. However, this preference was reversed in those who had previously consulted a nurse prescriber.

For both of the scenarios in the Discrete Choice Experiment certain attributes of the consultation, such as listening to patients views about medicines and explanation about medicines, were considered more important than the profession of the prescriber.

1.5.5 Educational programmes for nurse and pharmacist independent prescribing

The study findings indicate that current educational programmes of preparation for nurse and pharmacist prescribing are operating largely satisfactorily, and provide fit-for-purpose preparation for current nurse and pharmacist prescribing roles. However, we recommend that attention needs to continue to be given to nurses' and pharmacists' assessment and diagnostic skills which underpin their independent prescribing role.

1.5.6 Views of other health care professionals

Nurse and pharmacist prescribers report making a positive impact on the policy targets for non-medical prescribing: quality of care, clinical effectiveness, patient access and choice.

Results indicate that non-medical prescribing was generally viewed positively by other health care professionals, although there is some evidence to suggest that some doctors remain unclear about nurses' and pharmacists' prescribing authority.

1.6 Conclusions

Nurse and pharmacist independent prescribing in England is becoming a well-integrated and established means of managing a patient's condition and giving him/her access to medicines. Evidence indicates that, overall, educational preparation is fit-for-purpose. Nurse and pharmacist independent prescribing is operating safely and prescribing is clinically appropriate, with most Trusts having established core clinical governance and management strategies for non-medical prescribing. Evidence indicates that overall patients are satisfied with their experience of nurse and pharmacist prescribing. Recommendations to inform planning for current and future nurse and pharmacist prescribing have been made.

References

Department of Health (2000) *The NHS Plan: a plan for investment, a plan for reform*

Department of Health (2006) *Improving patients' access to medicines: a guide to implementing nurse and pharmacist independent prescribing within the NHS in England*