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Community matrons' experience as independent prescribers

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**Background**

Community matrons were introduced by the Department of Health (DH) in 2004 as part of an initiative to improve the management of patients with complex long term conditions and to reduce unplanned admissions to hospital. The defining feature of this role is the possession of advanced practice skills including an independent and supplementary prescribing qualification.

Although research has been undertaken into the prescribing practices of general practice-based nurses and district nurses there is little known about prescribing amongst community matrons. Gaining an understanding of the prescribing experiences of this group of practitioners and the relevance of this qualification in reducing unplanned hospital admissions could help establish the importance of this qualification to the community matron role and identify areas for support and development.

**Literature Review**

To ensure all existing relevant research was accessed, a comprehensive search of relevant databases was undertaken. Those selected were Cinahl, Medline and Embase to ensure nursing, medical and pharmacological literature was included. The Cochrane library was also searched for any relevant systematic reviews. An opportunistic search on google scholar was also undertaken.

As there was very little research into community matron’s experiences on prescribing the search was broadened to include district nursing, primary care and other community nurses’ prescribing practice.

**Nurse prescribing**

Research by Courtenay and Carey (2008) and Latter et al (2012) shows that most nurse prescribers are regularly using their prescribing qualification, the majority of whom are based in primary care and working in general practice.Increased autonomy and job satisfaction from prescribing is a shared theme amongst prescribers in primary care including both community nurses and those working in general practice (Young 2009, Daughtry and Hayter 2010).

Smith et al (2014) found that most nurses felt their prescribing courses met their educational needs and that adequate support and development was available. ***Stenner et al (2012) and Carey et al (2013) however, found nurses prescribing for specific conditions limited the range of medications they prescribed in the absence of specialist training.***

There appears however to be a disparity in the availability of prescribing support between those working in general practice and those who are community-based, with community-based prescribers experiencing more difficulty accessing support (Downer and Shepherd 2010, Smith et al 2014). Lack of confidence and difficulties with local prescribing arrangements such as access to electronic records and difficulties with recording prescribing interventions, have also been identified as restricting prescribing practice in community nurse prescribers (Hall et al 2006, Downer and Shepherd 2010).

There is little research relating directly to community matron prescribers. Cubby and Bowler (2010) found in their research into community matrons’ perceptions of the impact of their role in the management of patients with complex long term conditions that the availability of supervision and support was lacking for this group, which is similar to themes identified for community nurse prescribers.

Searching the literature has revealed a scarcity of studies that look specifically at community matron prescribing. As the community matron role is based outside the general practice setting it is possible they may encounter many of the problems cited as barriers to district nurse prescribing. Understanding the experiences of community matron prescribing would potentially be a first step towards facilitating appropriate processes and support to be put in place, thereby assisting community matrons to fulfil their role in the management of long term conditions and avoiding unnecessary hospital admissions.

**Aims and objectives**

This aim of this study was to explore the prescribing experiences of a group of community matron independent/supplementary prescribers including their prescribing practices and any influencing factors on this.

**Research design**

A qualitative ***design*** was adopted to gain an insight into the prescribing experiences of community matrons**.** Semi-structured interviews were used including the use of open questions in the interview allowing the interviewee to answer freely (Flick 1998).The interviews were recorded using a digital recorder and then later transcribed. Braun and Clarke’s (2006) six phases of thematic analysis was used to analyse the data. ***This provided a structured approach with clearly defined phases including coding and the identification and refining of themes.***

**Sample**

A purposive sample of at least 15 community matron independent /supplementary prescribers from two local primary care trusts was proposed.A convenience sample of two primary care trusts were chosen for their proximity. The two trusts between them included a large geographical area with inner city, rural and suburban areas. Inclusion criteria were to be working as a community matron and to possess an independent prescribing qualification.

**Recruitment**

Non-medical prescribing leads from the two local trusts were approached. Invitations were sent by e-mail from the leads to all 47 community matrons from both trusts. Details of the study were also available at a non-medical prescribers’ conference attended by prescribers from both trusts. The decision to take part was dependent on the community matron then initiating contact with the researcher, thereby ensuring there was no coercion in the decision to participate.

**Ethics**

Ethical approval was sought from the University of Southampton Faculty of Health Sciences Ethics Committee (Ref 8784) and from the Research and Development departments from both primary care trusts prior to commencing the research.

**Anonymity**

Participants were numbered to protect their identity during transcribing. No reference was made to the participants’ specific places of work, employers or the names of participants.

**FINDINGS**

**Sample**

Seven community matrons were recruited, five from Trust A and two from Trust B**.** Of the community matrons interviewed, four had been in the role for six years, two for three years and one for nine years. The length of time of holding an independent prescribing qualification ranged from two to eight years with most having been prescribing from four to six years. ***There was no use of supplementary prescribing amongst the matrons.***

**Qualifications**

All participants were registered nurses with a non-medical prescribing qualification. All participants had completed a history-taking and physical assessment course either as part of a degree course or as a stand-alone module at degree or masters level.

**THEMES**

Three major themes were identified from the data analysis.

**1. The importance of prescribing knowledge**

All community matrons interviewed found the knowledge gained from undertaking a prescribing qualification as essential to their role.

*‘The thing that I’ve found over the years incredibly important in the role is the actual knowledge that underpins it all. So, the fact that I’ve done the course, that I recognise and understand the drugs, that I can advise patients properly, that I can sit there with my BNF and talk them through things, that I can recognise if the doses, you know, are wrong or if they need an increase or decrease in their medications all of that..’ CM1.*

For three of the matrons this extended to the management of the deteriorating patient where this knowledge enabled them to feel more confident in assessing the deteriorating patient.

*I had the confidence then to say, right today we’re going to leave your diuretics alone but you know the next time we’re going to double the dose for 3 days or whatever..’ CM1.*

However, three matrons felt the physical ability to write a prescription was less important than the actual knowledge gained from undertaking the prescribing course.

 Conversely, the other matrons valued the ability to write a prescription finding it convenient and time saving and cited this as key component in managing the deteriorating patient, particularly where this enabled acute medications to reach the patient in a timely manner.

*‘I* *think it’s because of timing issues, you know, because normally if it’s someone who has rung in the morning, then they won’t get a GP visit ‘til the afternoon and if they’re last on the list by then* *they’re so far down the line they’re in hospital. So timing issues are very important in managing a deteriorating patient ….you get it on board quicker, I mean it’s a twelve hour difference sometimes’ CM5.*

**2. Community matrons’ prescribing practice**

**Frequency of prescribing**

There was a range of frequency of prescribing amongst the participants. Three matrons prescribed on average once a week, one matron prescribed two or three times a week and three matrons prescribed on a daily basis.

**Limited personal formularies**

All community matrons were prescribing a similar range of medications. The greatest consensus was in prescribing for exacerbations of chronic obstructive pulmonary disease (COPD) and antibiotics for infections. There was a noticeable caution in the approach to prescribing for heart failure with references to only titrating existing medication or seeking support from the GP.

*‘I wouldn’t prescribe anything new (for heart failure) but I might tweak things that are already there, particularly diuretics , I might sort of tweak one way or another… but I really wouldn’t prescribe much for heart failure, I’m not familiar with the heart failure drugs other than diuretics to be honest’ CM6.*

There was variation in confidence in prescribing for conditions beyond this core group of drugs.

*‘I’m happy with exacerbations and chest infections, so like UTIs and wound infections, but anything that’s going beyond that I just don’t feel confident in myself to be going out and doing that, I really feel that to me is a doctor’s job’ CM7.*

**Expansion of personal formularies**

There was little evidence from the interviews that the matrons felt they needed to expand their prescribing practice. All matrons seemed to find their current prescribing practice adequate in fulfilling the role.

‘*You see I don’t think I have increased my scope over the years to be frank, I think I have quite a limited range that I feel confident doing, using and I haven’t gone outside it…I think the knowledge and skills are there to impart information and support to the patients.. but I certainly don’t feel the need to suddenly become an expert in you know, Parkinsons meds or anything, I just wouldn’t touch it’ CM1.*

**Barriers to prescribing**

Three of the matrons described GPs’ understanding of and confidence in nurse prescribing as a potential barrier to be overcome. They identified the importance of GPs gaining trust in their practice as vital in the facilitation of the prescribing.

*‘It was building that trust that you could do it and you were careful and you were competent and you observed safety aspects’ CM3.*

There was no consistent theme identified around local arrangements influencing the practical difficulties of prescribing. There were some examples where good relationships with GPs improved the ability to transfer information, but this was not universal. IT systems were problematic for some and not for others. Some of those who did not have easy access to electronic records negotiated recording difficulties by fax or email.Most matrons had negotiated systems around the collection and delivery of medication.

 *‘I kind of set up chemist friends and I would phone them and say I’m going to be coming in and in the end they’d say oh yes, because they’d prescribed and issued it before and they’d be quite happy with that’ CM3.*

Even those who ended up delivering the medication themselves still felt it was beneficial.

*‘If you have got somebody that hasn’t got anyone to go and pick it up, it’s OK, then I’ll go and drop it off.. you’re a delivery service, but even now it takes so much less time than waiting for the GP’ CM5.*

**Safe practice**

It was evident from all interviews that the matrons considered that they were practising safely and within their scope of competence. All were anxious to ensure accurate records were kept.

**3. Support for community matron prescribers**

Overall, the interviews highlighted that support for prescribing community matrons was adequate, but it lacked formal structure.

**Continuing Professional Development (CPD)**

All community matrons cited non-medical prescribing forums or meetings set up by the trust as the main CPD available to them. However, nearly all expressed some difficulty with accessing the sessions.

*‘It’s not always easy – it’s in work time and that often stops you, you know on a day if you’ve got a sick patient you have to see rather than..’ CM2.*

Other CPD accessed by a few matrons included University conferences and National Prescribing Centre conferences which were infrequent and not readily available. Informal CPD was varied from journals, prescribing websites and pharmacists but there was no pattern to these.

**Prescribing support**

The most commonly cited prescribing support available to the matrons was from GPs and this was consistent from all participants. Four of the matrons used nurse prescribing colleagues for support and five of the matrons had access to an older persons’ consultant who they also accessed for support. There was no formal prescribing supervision in place for any of the matrons.

*‘I suppose the bottom line is I don’t get any formal support. I mean I get support in an informal way from GPs and the consultant and my colleagues’ CM1.*

**Confidence in prescribing**

Five of the community matrons expressed a sense of caution towards their prescribing role.

*‘When you suddenly realise the responsibility of handing that piece of paper so I always think twice about what I’m doing…. I can advise any doctor about anything but actually when it comes to writing it I do double question myself.’ CM5.*

Despite these comments all the matrons felt reasonably confident prescribing within

their identified scope of practice.

**Additional support required**

There was no consensus about whether additional support was needed or what form it might take. One matron was very keen for additional support. She felt there was an assumption that she had great confidence in her skills when she didn’t and suggested spending supervised periods each year with a doctor undertaking joint visits and being challenged to make all the prescribing decisions.

*‘I think they (doctors) sort of assume sometimes that we know more than we do, and I think they assume we have huge confidence in our skills when we don’t and what I would love is to sort of have a week or two a year when I was buddied up with a doctor and he or she made me do all the prescribing. It would be terrifying but it would really make me learn I think’ CM1.*

**DISCUSSION**

The aim of this research was to develop an understanding of community matrons’ experiences of prescribing. Three major themes emerged.The study found that community matrons valued prescribing as important to their role, a finding consistent with many other studies of nurse prescribing (Young 2009, Daughtry and Hayter 2010, Downer and Shepherd 2010, Cousins and Donnell 2011) The knowledge gained from prescribing training was highly valued by the matrons in enabling them to manage patients with complex medical conditions and multiple medications. This distinction of the benefit of the knowledge gained from the prescribing qualification as opposed to the complete process of prescribing is somewhat unique in the literature. It indicates that in-depth pharmacological knowledge is applied in many ways in managing community matron patients and does not just underpin writing a prescription.

Similar to other studies on nurse prescribing, the majority of matrons commented on the convenience and time-saving benefits of issuing a prescription (Young 2009, Cousins and Donnell 2012). Prescribing was found to be efficient, but more importantly in the case of preventing unnecessary hospital admission where the ability to get medication quickly to a patient is key, was found to be invaluable. Clearly this is an important finding, and outlines the potential contribution that nurse prescribing can make to patient care and potential cost savings for the NHS.

All community matrons interviewed were using their prescribing qualification which is consistent with findings from other studies of nurse prescribers’ prescribing practices (Smith et al 2012). There was no consensus amongst the matrons as to whether local prescribing arrangements were barriers to prescribing. Hall et al (2006) and Downer and Shepherd (2010) had both found these to impact on community nurse prescribing. However most matrons had overcome difficulties with the collection and delivery of prescriptions, and acknowledged that there was no easy way to get a prescription to a housebound patient late in the afternoon. The personal difficulties to the nurse this may have caused was compensated by the fact that had this been left to a GP they would not have got their medication until at least the next day.

In addition to overcoming logistical barriers to prescribing there was a recognition amongst several of the matrons that the GPs themselves can potentially be obstructive in nurse prescribing, particularly when they don’t understand or have experience of the role. This is a common theme in the literature ( Cubby and Bowler 2010, Daughtry 2010, Hall et al 2006). ***The matrons identified the importance of establishing trust with the GPs in enabling their prescribing practice.*** It was apparent from the interviews that the matrons had found ways to overcome this although it was a potential hurdle each time a new GP was encountered. This doggedness that seems a recurring feature in those undertaking the community matron role is demonstrated in research by Cubby and Bowler (2010) where, in response to potential barriers to the role, there is a belief by participants that most can be overcome by the right individual.

There is little to be found in the literature as to which medicines independent prescribers are actually prescribing. Latter (2012) describes nurses prescribing a range of drugs for acute and long term conditions according to their role but is not specific in detail. A service evaluation by Brookes (2010) looked at prescribing practice of community matrons undertaking routine medication reviews. She found the common conditions prescribed for were constipation, respiratory conditions and pain.

The findings from the interviews in this study showed that the matrons were prescribing a limited but similar range of medications. Interestingly, there was not a feeling that this range of medicines needed to be extended. The interviews also showed the matrons considered they were prescribing safely and within their scope of competence. However, in doing this they were referring back to GPs to prescribe some medicines for patients, and it is unclear if this makes for the most seamless, best quality care delivery for the patient. Further research into the patient experience of this would be useful.

Generally the interviews showed that matrons felt well supported in their prescribing role. The main support was from GPs. This is consistent with findings from a national survey evaluating education and CPD for nurse prescribers (Latter et al 2007) which showed GPs as providing on-going support and supervision for this role. The matrons identified formal structured support both in the form of mentorship and CPD as lacking in accessibility and regularity, however they all had identified networks of support for themselves. Research has shown a lack of prescribing supervision and support for community nurse prescribers Cubby and Bowler (2010), Downer and Shepherd ( 2010). Conversely Latter et al (2012) in their evaluation of independent nurse and pharmacist prescribing reported confident prescribers overall who were able to access CPD and support from an experienced prescriber. This difference in support needs may reflect not only the prescribing role of the participants but may also reflect the level of experience of the participants. In both Cubby and Bowler and Downer and Shepherd’s research the prescribers were relatively new to the role. The matrons participating in the interviews for this research were all relatively experienced, with the exception of one, and subsequently had over time established their support mechanisms. However, the research interviews do imply a lack of a robust system around prescribing support and a more structured approach to this for community matrons may be beneficial in particular for those new to the prescribing role.

Coupled with this satisfaction with their support, the majority of matrons exercised considerable caution in their prescribing and were confident prescribing within their limitations. There are several references in the interviews to this anxiety being part of safe practice and necessary in avoiding complacency.

There was no consensus amongst the matrons as to what additional support was needed and certainly the matrons were not expressing a pressing need to extend the scope of their prescribing practice.

Clearly, from the interviews, management of heart failure is an area where matrons feel under-confident and often refer to a GP for prescribing support. ***It was unclear from the interviews if this represented a need for pharmacological or disease management support.*** ***It is possible*** that with ***appropriate*** support the matrons may feel empowered to identify areas of their practice such as heart failure where they could expand their skills and knowledge, thus improving the patient experience and possibly preventing hospital admission through speedy prescription of medicines.

**Limitations**

**Sample size**

 Recruitment resulted in only seven participants and although there was evidence of data saturation around key themes, it was not achieved for all themes. Despite the small number of participants, there was a range of experience and qualifications amongst the matrons who were working in both rural and inner city settings and therefore could be considered representative of community matrons more generally.

**CONCLUSION AND RECOMMENDATIONS**

This research has given valuable insights into the experiences of community matrons in a prescribing role.

It has shown that community matrons consider a prescribing qualification as essential in fulfilling the role of a community matron. They valued in particular the knowledge gained from the prescribing course which was singled out as important over and above the actual ability to write a prescription. The ability to write a prescription was also valued as it released matrons from lengthy waits for ***discussions with*** GPs and in some instances this ability to deliver medication in a timely manner was believed to have prevented unnecessary admissions to hospital.

The study found that community matrons are regular prescribers and showed resilience in their ability to overcome barriers to patients accessing medicines, perceiving the benefit to the patient of receiving the prescription as outweighing ***any personal inconvenience.***

All the matrons were prescribing from a limited range of medicines and conditions and were accessing support for similar prescribing scenarios with no desire to increase the scope of their prescribing. Whilst this may have contributed to safe practice, the impact of this limited scope on the patient experience – particularly for patients who require a range of medications, including some outside the community matron scope - is unclear and needs further research. Support for prescribing and CPD was available but difficult to access and infrequent.

**Recommendations for future research**

Further research into community matrons’ prescribing experiences on a wider scale is required. It would also be useful to understand the effect of providing additional prescribing ***mentorship*** and support on the community matrons’ prescribing practices and whether this resulted in an increase in the range of medications prescribed and increased confidence in prescribing. This could be achieved by undertaking research that trials the provision of additional prescribing support from a designated ***mentor*** and monitoring the effect of this on prescribing practice.

**Key Points**

A prescribing qualification is essential in fulfilling the role of the community matron and contributes to the prevention of unnecessary admissions to hospital.

The knowledge gained from undertaking a prescribing qualification is highly valued, over and above the physical ability to write a prescription.

Community matrons are regular prescribers, prescribing from a limited range of medicines and for a limited range of conditions.

Support for prescribing is available but usually informal and sometimes difficult to access.

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