

Consultation skills in relation to nurse prescribing



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Nurse prescribing was translated into reality in the latter part of the 1990's when a cohort of about 1, 200 nurses received specialist training in order to allow them to feel confident and competent in the prescription of certain drugs and medications.

In the best traditions of scientific endeavour, they were subject to a barrage of audits and studies to see how they actually performed. As in any new project there were inevitable protagonists and detractors and the initial results of the first eight studies were extremely positive. (Legge 1997) the accumulative results of the initial studies showed that nurse prescribing had been proved in terms of safety, efficacy and improved working practices.

The reports did not make any comment upon the cost-effectiveness of the prescribing as the cohort studied was too small for statistical analysis. The head of the evaluation team (Prof. Luker 1997) commented that at best, nurse prescribing should be cost neutral – why should it be any cheaper?

By 2000, the first comparative studies were emerging with sufficient cohort size to give a meaningful evaluation of the scope and efficiency of nurse prescribing. Venning (et al 2000) compared efficiency and cost of a cohort of nurse prescribers with doctors in the same geographical area. The study cohort was over 1, 300 patients.

This particular study was extensive in its analysis and many of the results are not particularly relevant to the subject of this essay, but the significant outcomes showed that there was no significant difference in health outcome, prescribing patterns or prescribing cost. Nurse prescribing was therefore

proving itself to be both an effective and efficient resource for the NHS.

(Little et al 1997)

Consultation and communication skills

Empowerment and education of patients is now well recognised as an important goal but most healthcare professionals. (Richards 1999) it follows that if patients are to be involved then their particular priorities must be ascertained and addressed, usually in the mechanism of the consultation. A frequent finding in many of the studies on the subject is the fact that patients tend to prefer prescribers (nurses or doctors) who listen and also allow them to discuss their problems in an unhurried fashion. (Editor BMJ 2000)

This essay is particularly directed to the issue of consultation skills in relation to nurse prescribing. Although we have briefly examined the overall issues of nurse prescribing, the consultation is obviously the core skill required to establish the diagnosis and therefore the appropriate treatment and prescription. Many studies have looked at the influence of communication skills on prescribing and other factors related to the consultation. (Richards 1999)

Many authorities (Butler et al 1998) advise that the prime skills associated with the prescribing process are:

Adequate exploration of the patient's worries

Adequate provision of information to the patient regarding the natural processes of the disease being treated

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The advisability of self-medication in trivial illness

The various alarm symptoms that should be notified to indicate that there may be problems with the treatment. (Welschen et al 2004)

These various aspects are explored further in a particularly well written and informative book by Platt and Gordon (1999) it reflects on the fact that doctors and nurses are not generally particularly well trained in the art of communication skills. In the words of the author we 're not very good at transmitting information, and we're no better at picking up the signals that patients try to send. Critically, they make the point that individual prescribers are not particularly good at varying their approach to the different type of patient.

Clearly, the better the level of perceived empathy between prescriber and patient, the greater the level of compliance is likely to be. This is likely to be reflected in greater patient satisfaction, greater compliance with instructions generally and improved outcomes and again, in the words of the authors fewer lawsuits

This particular book highlights and gives practical advice on all of the common pitfalls of prescriber – patient communication. The way that prescribers will often duck issues where they feel uncomfortable or feel that their knowledge is not particularly sound, or perhaps fail to respond to the distress signals sent out (either verbally or non-verbally) by the patient. They also highlight the dangers of closing the conversation early due to pressure of time and not adequately exploring ambiguous answers.

The hostile and the heart-sink patient can be a particular headache to the prescriber and inappropriate decision can be made unless great care is taken to specifically tackle these issues. (RPSGB 1997)

Some commentators in the field of nurse prescribing have referred to the fact that the skills of communication, when they have been taught, have concentrated mainly on the fields of history taking and diagnosis. The issue of communication in relation to prescribing has received much less prominence. (Elwyn et al. 2000)

The paper by Cox (et al. 2000) found that it was common practice for prescribers to initiate the discussions about just what medication there were going to prescribe, rarely refer to the medicine by name and equally rarely refer to how a newly prescribed medication is perceived to differ in either action or purpose, to those previously prescribed. Patient understanding is rarely checked as it is usually assumed after the prescriber has given the prescription. Even when invited to do so, patients seldom take the opportunity to ask questions. (Cox et al 2000)

The same author found that prescribers would emphasise the positive benefits of the medication far more frequently than they would discuss the risks and precautions, despite the fact that the patient's perception was that such a discussion is seen as essential.

In summary, this leaves a situation which is open to misinterpretation, uncertainty as a result of unaddressed worries and for patients to be ambivalent towards the medication that they have been prescribed. (Drew et al. 2001). It clearly is not a situation which one could have confidence that

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the patient has a sound knowledge base about his treatment and has a positive attitude towards compliance.

The point relating to communication failure resulting in poor treatment outcome (primarily in relation to non-adherence to treatment instructions) was explored in depth in an excellent paper by Britten (et al 2000). The various consultation skills were critically analysed and broken down into 14 different categories of misunderstanding. In short, all of the failures of communication were associated with a lack of the patient's participation in the consultation process. Significantly, all of these 14 categories were associated with potential or even actual less than optimal

Outcomes as they resulted in either inappropriate prescribing or inadequate treatment adherence. It was very significant that the authors concluded that many of the errors were associated with assumptions or guesses on the part of the healthcare professional, and in particular a lack of awareness of the relevance of patient's ideas and beliefs which influenced their compliance with the prescribed treatment. (Elder et al 2004)

There is evidence that failure to actively engage in, or even consider, the patient 's perspective is a common failing amongst prescribers. (Britten et al 2000). Many take the view that simply arriving at and stating a diagnosis is sufficient credibility for the provision of a prescription.

Even when drug therapy is considered essential (such as insulin and thyroxin) many patients will experiment with dosages and drug-free periods. (Barry et al. 2000). It follows that such experimentation is likely to be all the greater when medication is used when the benefits are less immediate (eg. <https://assignbuster.com/consultation-skills-in-relation-to-nurse-prescribing/>

In prophylaxis). If the prescriber is aware of these factors, it will undoubtedly help to achieve compliance if they are overtly addressed during the consultation process.

Concordance vs. compliance

Elwyn (et al 2003) took a slightly different approach with regard to the consultation process and prescribing. They advocate the process of concordance which is described as the process whereby there is a negotiation between the patient and the prescriber which involves a discussion about the perceived benefits and drawbacks of the proposed medication, together with an exchange of beliefs and expectations.

This terminology reflects not only a change in emphasis but also a change in attitude of the prescriber. This area used to be termed compliance which was a reflection of the – now outmoded – concept of implicit power and authority invested in the prescriber. The term was seen as being authority laden (Marinker 1997) where it was expected that patients complied implicitly and without question when a prescription was given. There was little acceptance that patients would actively participate in the decision making process that surrounded the generation of the prescription. (Cox et al. 2002)

At this point in time, there is little published evidence that this process actually leads to improved clinical outcome measures, but consideration of ethical principles would allow us to conclude that the involvement of patients will inevitably result in safer and better patient care. (Elwyn et al. 1999)

If we examine this argument further, any healthcare professional will appreciate that a great deal of modern medical treatment involves prescribing in one form or another. We also know that a substantial proportion of the medication that is currently prescribed is not taken or, worse still, inappropriately utilised. (Haynes et al 2003).

Careful research shows that where this occurs it is primarily due to a conflict between the prescriber's views and those of the patient. (Britten et al 2003). Further studies have shown that where prophylactic (or preventative) prescribing has occurred the situation is statistically worse. One can presume that this is mainly because, in these conditions the patient tends to be asymptomatic and therefore the perceived need to take medication may well be less. Again, this reflects a failure of communication between patient and prescriber. (Coulter 2002)

As a result of this, the prescriber, in general terms, has to be aware of the possibility of what is known, in academic circles, as intentional dissent. The patient may choose to actively disagree with the prescriber's instructions because they may either have become party to other information about the medication, or because they may have experienced some side effect and, being not fully appraised of the reasons for taking prophylaxis, may simply choose to discontinue it. (Barry et al. 2000)

Conclusions

The last decade has seen important strides forward in the field of nurse prescribing. The success of this venture would strongly argue that it will progress further still in the future.

Hand in hand with this success goes the realisation that nurse prescribing carries with it a responsibility to fully understand the issues that relate the act of prescribing to the eventual treatment outcome, together with the factors that tend to confound such linkage. The progressive acceptance of the paradigm of concordance (by all prescribers – not just nurse prescribers) offers all healthcare professionals a mechanism to move towards ever safer and more successful prescribing.

Accurate identification of the patient's perspectives, needs and beliefs and then the addressing of any significant differences between these and the prescriber's requirements, are seen to be progressively more important in the successful delivery of nurse prescribed health care.

The advent of nurse prescribing brings added responsibility to the more traditional role of the nurse. It is important not to neglect the importance of the role of reflective practice in this area (Gibbs 1998). It is not just the act of writing out the prescription that is important, but it is the understanding of the processes and dynamics of the interactions that are taking place between prescriber and patient that are the fundamental key to good prescribing practice (Kuhse et al 2001).