Nurse prescribing in the community

Introduction

This essay analyses a recent (i. e., not older than 5 years) development in community nursing practice for adults. The essay picks one area of the community nurses' role and explores the impact of that role on patient care. The role that will be analysed is nurse prescribing. The essay includes the key policy drivers behind the area of development and includes the analysis of factors such as inter-professional working and user involvement. The essay considers the practical application of the role, including barriers to its success. The necessary skills involved to ensure patient care continues to improve are also discussed. Evidence that evaluates the effectiveness of the role is also explored.

This essay begins with a brief history of nurse prescribing, and then discusses the possible barriers to the success of community nurse prescribing, including the fundamental need to make accurate assessments of the patient's conditions, their history (i. e., making adequate notes regarding their symptoms and the medicine that has been prescribed), the necessity for clear communication and consultation with all patients and the development of a working diagnosis, based on the best information available at any one particular time. Issues such as when to prescribe, and when not to prescribe, are also discussed, as is the issue of possible treatment of the patient's condition without medication, or through referral for further treatment with other health professionals. Other possible barriers to the adequate implementation of nurse prescribing are also discussed, including the relationship with the patient, for example. Patient partnership in terms of taking medicine, including an awareness of, and sensitivity towards, cultural

and ethnic needs, is also discussed, as is the issue of concordance *vs* . compliance.

Nurse prescribing began in earnest in 1994, and, since that time, the number and type of nurses who are professionally able, and legally allowed, to prescribe medications has increased significantly, as set out in the *Medicinal Products: Prescription by Nurses, Midwives and Health Visitors Act 1992,* which came in to effect in 1994 and, generally, under the Patient Group Directions scheme. Independent (or nurse) prescribing is where the prescriber takes full responsibility for the clinical assessment of particular patients, from making the diagnosis, to implementing the necessary clinical management, to taking responsibility for prescribing (see NMC, 2005).

When nurse prescribing was first introduced, in 1994, there were two main categories of nurses who could prescribe medication: independent and supplementary prescribers (including district – or community – nurses, health visitors, practice nurses and midwives). There were several requisites for nurse prescribing to be allowed: the nurses should have completed the NMC approved programme of preparation for nurse prescribers, the nurses should have had their prescribing status entered on to a register of nurse prescribers, the nurses should be employed by an NHS Trust, and they should be working in a post designated for prescribing (see NMC, 2005). Nursing staff were, at this time, when prescribing, professionally responsible, on an individual basis, for any instructions that were given to patients (see the NMC *Standards for conduct, performance and ethics*).

Independent nurse prescribing came, fully, in to effect on 1 st May 2006, however, with the designation of ‘ nurse independent prescribers’. Nurse independent prescribers are allowed, by law, to prescribe any licensed medicine for any medical condition that is within their competence to diagnose (see Department of Health, 2008). Nurse independent prescribers are also legally able to prescribe ‘ off-label’ or ‘ off-license’ (i. e., for pediatric cases), within the bounds of their full clinical and professional responsibilities as laid down in guidelines from the Nursing and Midwifery Council and with the caveat that nurse independent practitioners are professionally responsible for their own actions (Department of Health, 2008).

Essentially, prescribing by nurses fits in to the framework of evidence-based practice that is currently in place within the NHS setting. In addition, prescribing by nurses is also governed by the framework for clinical governance, in that nurse prescribers need to be aware of the current evidence base for a particular diagnosis or treatment regime, and that they need to be fully versed in the relevant literature, in terms of knowing that what they are diagnosing, and prescribing on the basis of that diagnosis, is the best current approach to dealing with the condition the patient is presenting with and knowing that this treatment option has a high chance of success for each particular patient. Essentially, the *evidence-based* approach to prescribing by community nurses, set up, as it is, within the clinical governance framework, ensures best practice and the best treatment for patients, according to the guidelines of their professional body and current best practice as suggested by the research.

This part of the essay discusses how important it is for an accurate assessment of the patient's condition to be made, and how important it is for the patient's history to be recorded. The need for clear communication and consultation with patients is also discussed, as is the concept of a working diagnosis based on the best possible information.

Community nurses, who often see patients on a regular basis, are able to build up a rapport with their patients, which means that, more often than not, a full and concise medical history can be gained from the patient, which can be useful in determining the medication, and other treatment routes, that are necessary. Even though the community nurse creates this rapport with patients they see on a regular basis, not all of the patients they will see during their working day are regular, long-term, patients, and so it is fundamental that community nurses have good communication skills, in terms of creating clear communication channels between themselves and their patients. This involves not only communicating clearly, to the patient, what is required of them and what they will be doing with the patient, but also fostering clear communication from the patient, in terms of gaining a clear medical history from the patient, in order to be able to make a diagnosis of the patient's condition.

This involves not only finding out the historical antecedents of the patient's current condition but also finding out how the patient feels now, what medication has been taken, or is being taken, and finding out how any previous medication has altered their condition, for better or worse, so that alternative medication can, perhaps, be prescribed. An accurate report of this communication with the patient needs to be left in place, following this

patient-nurse dialogue, which should, ideally, include both the opinion of the patient and the results of any diagnostic tests that have been previously performed or that the community nurse has ordered. This is necessary so that any other community nurse who might be called on to treat the patient has a comprehensive record of the patient's history, including the medication that has been prescribed.

For a community nurse to be able to prescribe a medication to a patient of theirs, they need, therefore, to communicate with the patient to be able to arrive at a working diagnosis of the patient's condition. This is usually performed on the basis of the information the community nurse has to hand i. e., notes made from previous interactions with other community nursing staff, the consultation with the patient and the observations that the community nurse made, as part of the consultation. Once all of this information has been collated and assessed, a diagnosis will be arrived at, and the nurse prescriber will then prescribe the appropriate medication based on this diagnosis.

It is important for the community nurse, who is able to prescribe, to realize that not all patients, or all conditions, will need a prescription: some diagnoses may be best treated through non-drug treatment or many need a referral for further analysis or treatment, by a specialist, for example. The decision as to when to prescribe medication, or not, is thus in the hands of the community nurse responsible for that patient, and can only be made, as has been seen, when the nurse feels they have all of the necessary information they need to make a full diagnosis, on the basis of which they feel confident about prescribing medication.

The community nurse thus has the capacity, and ability, to diagnose patients, which is made on the basis of clear, two-way, communication with the patient. The community nurse also has a responsibility to the patient to treat the patient in the most appropriate manner. This could be through the prescribing of medication or could be through referral to another health professional. Nurse prescribing is thus part of a process of interaction, and communication, with the patient, in terms of determining, to the best of their abilities, what is wrong with the patient and then working with the patient to ensure that the best course of action is taken, and fully implemented, in terms of ensuring that the condition is overcome and the patient gets better.

If a community nurse takes over the care of a patient from another community nurse or from a GP, for example, it is important to repeat the same process, i. e., to make an assessment of the patient, in terms of looking over the patient's previous notes, and communicating with the patient, in order to determine their problems and their views on their condition and then, using all of this information, to come up with an independent assessment as to the most appropriate diagnosis, and treatment options, for that patient. It is not sufficient to cimply, blindly, continue wit the same treatment regime as previously, without questioning this through consultation with the patient and without an assessment of their history. The community nurse may disagree with the previous diagnosis, or treatment options being implemented, based on the consultation with the patient, and the reading of the patient's history. In this case, the responsibility of the community nurse lies with the patient, and it would be necessary for the community nurse to make any necessary changes, as they

see fit, to the patient’s treatment regime, through the ceasing of the previous medication regime and the initiation of a new treatment regime. If, in this case, it is decided that the best thing for the patient is to change the treatment regime, this should be duly noted on the patient’s records, including some detail as to the reason why the treatment approach was changed.

This part of the essay discusses the relationship with the patient in terms of patient partnership in medicine taking, including awareness of cultural and ethnic needs. Patients have a right to be involved in the treatment process, in terms of being communicated with, throughout the diagnosis process, and having their opinions and views listened to, as part of the diagnosis process. Patients should, ideally, be given all the necessary information they need to make informed choices about their treatment, but, often, in community nursing situations, this is not possible, with the elderly, for example, who can often present with confusion, or with speakers of a language other than English who, if a translator is not present, can have difficulties understanding the information that is given to them, making the whole process of diagnosis difficult. Such barriers to effective nurse prescribing are commonplace and the professional community nurse needs to have actions in place to be able to overcome such barriers, in terms of delivering equal quality of care to all patients who might present to them. In some situations, however, it is a fact that concordance (not compliance) is often the best that can be achieved with particular patients, due to such problems, and this, unfortunately, has to be accepted.

As has been seen, for a community nurse to be able to prescribe a medication to a patient of theirs, they need to communicate with the patient to be able to arrive at a working diagnosis of the patient’s condition. This is usually performed on the basis of the information the community nurse has to hand i. e., notes made from previous interactions with other community nursing staff, the consultation with the patient and the observations that the community nurse made, as part of the consultation. Once all of this information has been collated and assessed, a diagnosis will be arrived at, and the nurse prescriber will then prescribe the appropriate medication based on this diagnosis.

Thus, it is important for the community nurse to realize that, although they may appear to be treating the patient in isolation, the patient has, in fact, a history of interaction with other nursing staff and health professionals, and often, in addition, with other professionals, such as social workers, for example, and that, as such, the community nurse has a role to play in inter-professional working. The various ways in which mental health problems are treated in the community can, for example, often lead to inter-professional working, with the community nurse needing to be well versed in how to work inter-professionally, in terms of how to fit in to an inter-professional team, for example. The community nurse who is responsible for nurse prescribing thus not only has to be able to communicate effectively with the patient but with other professionals who might be responsible for the care of the patient.

Conclusions

As has been shown in the course of this essay, there are many factors that need to be considered when a community nurse prescribes medication, for example, the need for clear communication with the patient, which is an essential ingredient for the success of treatment regimes, and the need for clear, concise, record-keeping which is essential to ensure the continuity of care for patients and to ensure that any necessary inter-professional working is successful.

This essay has, essentially, analysed a recent development in community nursing practice for adults, namely the issue of nurse prescribing by community nurses. The essay has explored the impact of this development on patient care, including a presentation of the key policy drivers behind the area of development and including the analysis of factors such as inter-professional working and user involvement. It was seen that prescribing by community nurses fits in to the current evidence-based framework of the NHS, within the framework of clinical governance, and that community nurses are also bound by their professional obligations when prescribing.

The essay also considered the practical application of the development of nurse prescribing, including barriers to its success. These barriers were identified as many and varied, including barriers to effective communication, through having patients who find it difficult to communicate, for one reason or another, or through problems posed by inter-professional working as part of an inter-professional team, which can lead to disagreements as to the most appropriate treatment regime, for example.

The necessary skills involved to ensure patient care continues to improve were also discussed, in terms of the professional obligations of the community nurse and their ultimate responsibility to the patient, in terms of ensuring that the principles of evidence-based practice are fundamental to the day-to-day working of the community nurse. The need for effective communication, between patient and nurse and between the nurse and other members of an inter-professional team was also stressed, as was the need for effective record-keeping, to ensure continuity of care for the patient and to ensure that the nurse prescriber has a record of every step of the diagnosis and treatment procedures, should anything go wrong, for example.

In summary, the essay began with a brief history of nurse prescribing, showing it’s development in the legislation, and then discussed the possible barriers to the success of community nurse prescribing, including the fundamental need to make accurate assessments of the patient’s conditions, their history (i. e., making adequate notes regarding their symptoms and the medicine that has been prescribed), the necessity for clear communication and consultation with all patients and the development of a working diagnosis, based on the best information available at any one particular time. If these channels of communication are not left open, and provided with the means for success, the role of the community nurse prescriber is made more difficult, with such barriers meaning that success of the nurse-patient relationship will, potentially, be jeopardized.

Issues such as when to prescribe, and when not to prescribe, have also been discussed, as has the issue of the possible treatment of the patient’s condition without medication, or through referral for further treatment with

other health professionals. The issue of stopping medication that has prescribed by other health professionals, which has been a controversial part of the development of nurse prescribing, has also discussed. Other possible barriers to the adequate implementation of nurse prescribing have also been discussed, including the relationship with the patient, for example. Patient partnership in terms of taking medicine, including an awareness of, and sensitivity towards, cultural and ethnic needs, has also discussed, as has the issue of concordance *vs* . compliance.

In summary, therefore, nurse prescribing, a recent development in community nursing, has meant many changes to the ways in which community nurses work, but, given the relatively low levels of requisites for successful implementation of this development (i. e., effective communication and record-keeping), the development has been successful, overall, in terms of releasing other professionals from the burden of prescribing and giving community nurses the freedom to manage their patients, from diagnosis right through to treatment. There are, as has been seen, various barriers to the success of community nurse prescribing, but these barriers can, in most cases, be overcome with creative thinking. Thus, in conclusion, the development of nurse prescribing has been a positive one, on the whole, for the community nursing profession, allowing an unprecedented level of freedom for community nurses and providing a revolution in patient treatment in the community setting.

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