

Factors for consideration in independent prescribing



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This assignment will consider the different treatment possibilities available for an illness resulting from an observed session. A short overview of the patient and their record will be presented, followed by a thorough examination of different medication possibilities, reviewing the quality of the literature and supportive facts. The pharmacokinetics and pharmacodynamics of every pharmacological choice will be rationalized. The legal, ethical and legislative side of the session will be contemplated which will also reflect on the responsibility of the prescriber.

The author is a nurse working in General Practice. The session being studied in this essay was undertaken by the author as the acting practitioner who is currently undertaking the non-medical prescribing course under the supervision of a Designated Medical Practitioner (National Prescribing Centre, 2005).

Independent prescribing is prescribing by a practitioner (doctor, dentist, nurse, pharmacist) who is held responsible for the review of the patient with identified or undiagnosed complaint and the assessments made regarding the needed clinical management, including prescribing and deprescribing (Department of Health, 2006).

Prescribing should be supported by a multi-disciplinary team, and it is important for any prescriber to make wise use of this benefit where available. This forms on the principles outlined in an older document which presented the concept of the supplementary prescriber, before non-medical independent prescribers were conceived (Department of Health, 2005).

The difficulty of supplementary prescribing is in its restrictions compared to independent prescribing: supplementary prescribers must work to a clinical management plan (CMP) which is a contractor chosen relationship between a doctor or a dentist, the supplementary prescriber and the patient. A CMP can only be represented after diagnosis is made by the independent prescriber, so supplementary prescribing certainly has its place, but it cannot give the diagnostic responsibility in the way that independent prescribing registration can.

Currently, all the authors work in consultations are supervised and are approved by a designated medical practitioner (DMP) (National Prescribing Centre, 2005).

This session was observed in practice and for confidentiality, no real names will be used, in accordance with the (NMC, 2018)

The patient was a thirty-eight male who was proven to have inflammatory bowel disease (IBD). This was formerly identified by colonoscopy; there was no additional substantial past medical history except having a grommet inserted in his right ear as a child. The patient presented with an exacerbation of his complaint. Throughout the session, it was recognized the patient had not been initiated on any pharmacological management for his complaint and had simply been acquiring over the counter analgesia which was paracetamol for pain control when required. A complete medication account was taken from the patient and he stated he had no allergies nor had he used any illicit drug use or herbal therapies. This was crucial for the session as this could provide important evidence which could stipulate

triggers for the exacerbation. It was also vital as the patient may have been taking a medication which may also be contra-indicated in their illness.(NICE, 2013).

After the proven record of IBD, a diagnosis was easily recognized, but another diagnosis could have been diverticulitis fitting to the intestinal discomfort, or gastroenteritis. It is crucial to ruling out red flags when a patient presents. Key red flags for IBD can be additional gastrointestinal complaints which may involve malignancy. (BNF, 2017)(NICE, 2013).

The initial choice with IBD is health promotion and education. Evidence recommends that lifestyle preferences may play a part in the exacerbation of symptoms. (NICE, 2013).

There have been worldwide papers observing diet and IBD. A Japanese study by(Zeng, L., Hu, S., Chen, P., Wei, W. and Tan, Y. 2017)realized that a high sugar and fat regime indicated to initiate an enhanced risk of IBD, although high fiber and vegetable consumption guard against IBD. The variance in genetics amongst Japanese and the western world transpired to not play a main part whereas a Canadian paper by (Amre, D. K., Mack, D., Israel, D., Morgan, K., Lambrette, P., Law, L., Grimard, G., Deslandres, C., Krupoves, A., Bucionis, V., Costea, I., Bissonauth, V., Feguery, H., D'Souza, S., Levy, E. and Seidman, E. G. 2008) found similar outcomes. The Canadian paper took many dependents and was organized throughout Canada commencing from three gastroenterology placements.

The discouraging attribute to this paper was that it was piloted in children with IBD. The outcomes obtained were compiled by a questionnaire; this <https://assignbuster.com/factors-for-consideration-in-independent-prescribing/>

report could have inadequacies as the discipline may fill the questionnaire out to give the answers the researchers want.

To guarantee the legitimacy of the questionnaire the examiner should carry out a retest approach, to ascertain if the same answers are given twice by the subjects. The research paper commenced in Japan likewise used a questionnaire system but acquiring the adult population factor. Other findings have discovered this inconclusive. Research commenced by (Van, D. Sc., Amini, M., Peters, V., Dijkstra, G. and Alizadeh, B. Z. 2017) reviewed the conservational and hereditary considerations stimulating IBD, incorporating diet. The report transpired a co-twin check procedure and found that smoking can aggravate the indications of IBD.

The comeback from the analysis was 80% and the audit revealed certain areas affecting IBD. This was a suitable answer, nonetheless, the value of the report may possibly be influenced by the answers given. This report's decision suggested former illnesses may escalate the risk of IBD. (Zeng, L., Hu, S., Chen, P., Wei, W. and Tan, Y. 2017) realized in their paper that family history remained a large risk threat, then again nutritional consumption can also take part in this role. Nutritional and also health guidance requires insignificant expense unless the patient has a need for a medical appointment to liaise with an additional healthcare provider such as smoking advice and weight management, largely these issues the service user can take full responsibility for.

Another possibility would ensure the commencement of medications like Sulfasalazine or Mesalazine. Sulfasalazine has a grouping of 5-aminosalicylic

acid (5-ASA) and Sulfapyridine. Mesalazine is a recent adaptation of this treatment which presently includes the 5-aminosalicylic acid (BNF, 2017). Roughly 93% of the medication quantity extends to the colon where microbes split the medication into sulfasalazine and Mesalazine and this is absorbed by the colon then expelled through the renal system. Medications such as these are prescribed to ease the exacerbation of IBD.

Another management therapy during exacerbations of IBD is corticosteroids. They usually are taken at the same time of other treatment for a brief phase. Prednisolone is usually the medication prescribed for this and can be dosed at 2.5mg up to 40mg once a day; this can also be increased to 60mg (BNF, 2017). This class of drug controls the stages of the inflammatory reaction.

Prednisolone is broken down by the liver which ensures a lengthier life which marks this drug appropriate for different time administration within some regimes. Kidneys expel this medication (BNF, 2017).

Verification that corticosteroids remain a treatment for severe exacerbation of IBD, long-term use is not appropriate (BNF, 2017) (NICE, 2013). The current cost of treatment is £4.29 for a hundred-tablet pack of gastro-resistant 2.5mg tablets. This treatment includes an excessive tablet inconvenience for patients, and will only be prescribed as a short-term course. The cost of medication could be a consideration in which type of drug is prescribed (BNF, 2017).

Lastly a management of Azathioprine, Azathioprine is a well absorbed oral Medication and has a half-life of 4-6 hours, this is then expelled by urination. (BNF, 2017).

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The evidence to support this treatment suggests that one of the reasons to commence this would be to avoid the usage of steroids; if a patient has had two or more courses of corticosteroids in a year then Thiopurines should be considered (NICE, 2013). A randomized, double-blind, placebo-controlled trial undertaken by (Alexander, D. B., Ligo, M., Abdelgied, M., Ozeki, K., Tanida, S., Joh, T., Takahashi, S. and Tsuda, H. 2017) took 66 patients who were on long-term Azathioprine treatment and wanted to establish if these patients could remain in remission if the treatment was withdrawn.

Further evidence supports that Azathioprine should be used as a maintenance therapy in IBD and that it may be used for four years (NICE, 2013). Due to the slightly different side effect profile patients who are unable to tolerate Azathioprine might be able to tolerate Mercaptopurine (BNF, 2017). There is a considerable difference in cost for these treatments, so it may be the case that patients are commenced on the cheaper medications and if that is not tolerated switched to the more expensive version.

After a discussion with the patient, the treatment options chosen in the consultation were option one and two. Option one was chosen as this empowers the patient to have some control over their condition by taking responsibility for their lifestyle choices. The patient was given health promotion information and advice on where to find help with regards to dietary advice and smoking cessation. The second option was chosen as it was felt that pharmacological intervention was required at this time to alleviate the symptoms of the patient's IBD that were not affecting their daily activities of living. If these options did not help, then there was the option to escalate to option three and option four.

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When deciding about a patient's treatment, the Doctor is personally and professionally accountable for the choices they make. They need to be able to justify the actions and decisions they make (National Prescribing Centre, 2005). Accountability for actions taken or omission committed is regarded with utmost importance in healthcare, especially in prescribing and medication administration (GMC, 2018). There are legal aspects of prescribing to consider. The prescriber has a duty of care to the patient and must use best practice to ensure the safest treatment possible (GMC, 2018).

All the decisions made in the consultation must be clearly documented as this is a legal document and may need to be referred to in the future. Clinical guidelines are only one option for improving care as this can provide a structure for the clinical management of a condition and can enhance confidence which also allows for continuity of care and helps to support evidence-based practice. Professional practitioners act autonomously when applying their own clinical knowledge and judgment. Though, as McKinnon (2007) suggests, the concept of autonomy assumes that the practitioner willingly reflects openly and honestly on their actions.

While considering legal aspects of prescribing this will bring in the ethical issues which need to be considered which considers four principles of medical ethics, beneficence, non-maleficence, justice, and autonomy can be applied to the patient in this consultation (Beauchamp, T. and Childress, J. 2013)

Beneficence was evident in the consultation as the aim of the consultation was to find a treatment to benefit the patient and to allow them to continue

without being affected by the symptoms or an exacerbation of IBD.

Beneficence may be difficult to achieve if the patient has a different view on what they perceive is in their best interest from the healthcare professional, this may be where negotiation skills must be developed.

Non-maleficence inspires the prescriber to consider the side effects of the various treatments and how they may affect the patient. The Dr informed the patient of the common side effects in the consultation of the different groups of drugs that were discussed. It was especially important regarding option three as the side effects of corticosteroids can be quite significant and the patient must be fully aware of this before commencing treatment. This was to prevent the patient from going away and finding this out after the consultation. Beneficence and non-maleficence may suggest conflict during the consultation as the side effects may outweigh the benefit in the short term, but this is where the patient must have a role in the decision and be more involved in agreeing their plan of care in accordance with the concept of autonomy reinforcing the importance of the rights of patients to individuality in healthcare (McKinnon, 2007). The ethical issue of justice is considered when the cost of the drugs is examined. Ethical justice may be out of the hands of the prescriber if the local health authorities only sanction the use of certain drugs (National Prescribing Centre (NPC) 2005). This may also be linked to a utilitarianism approach that is often taken with regards to local policies and procedure (NPC 2005). The patient may not be entitled to a medication that may benefit them because of the cost or it, not a drug chosen by the local health authority.

For the ethical issues discussed to be effective the patient's autonomy must be respected, the patient must be involved in the decision-making process. The consultation must leave the patient feeling that they fully understand their condition and their treatment options that are available.

The consultation that was witnessed was concordant as opposed to compliant; the partnership between the Doctor and the patient was established early in the consultation. This was instigated by the Doctor as the patient was being compliant at the start of the health interview. The Doctor did this by involving the patient in the decision-making process, but primarily by ascertaining what the patients understanding of their condition was and what they hope to receive from the consultation. The National Institute for Clinical Excellence, (NICE), 2013) recommends that the healthcare professional should adapt their consultation style to enable a concordant consultation to take place. They state that is should be recognized that non-adherence with medications is commonplace and that adherence should be assessed in a nonjudgmental manner. NICE (2013) advises that a holistic approach must be taken with the patient to develop strategies to improve adherence if this is an issue. The witnessed consultation proved to be successful in being concordant, but this will truly be measured at the patient's next appointment when the patient attends for follow up.

In conclusion to this case study, four different treatment options have been explored, looking at the evidence around them and the quality of the literature to support the use of these options. The legal and ethical elements of prescribing have been explored and the different ethical frameworks that <https://assignbuster.com/factors-for-consideration-in-independent-prescribing/>

are used when working toward a treatment plan. This is closely linked to accountability and the importance of understanding that as a prescriber, there is a professional and personal accountability. And finally, the importance of developing a good professional relationship with the patient in the interview so it may be a concordant consultation which will encourage the patient to be adherent with their treatment. This case study allows the enormity of the factors that need to be considered when making prescribing decisions.

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