Consultation on the Extension of Prescriptive Authority to Nurses and Midwives

Respondents may attach additional pages should they deem this necessary. Please include clinical examples, where possible, when completing response.

All interested parties are asked to respond in writing using this response sheet to the address below:

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All responses on this consultation process should be returned to the above address no later than **5pm on Monday 03 July 2006.**

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The Women's Health Council

1. What patient/client healthcare needs would be met by extending prescribing to nurses and midwives?

While the Women's Health Council has some reservations on the issue, it is broadly in favour of the introduction of nurse prescribing as a way to expand and complement the current prescribing arrangements. Studies in England (Avery et al., 2004; Latter and Courtney, 2004; Lewis-Evans and Jester, 2004; Cumberlege, 2003, and Sweden (Fernvall Markstedt, 2003) have shown that nurse prescribing has the potential to improve efficiency within the health sector as well as providing a more satisfactory service for its users. It complies with and, more importantly, promotes the principles of equity, people-centredness, quality of care and accountability as laid out in the Health Strategy (Department of Health and Children, 2001). As women, through their reproductive and caring roles, often find themselves in contact with the health sector, the introduction of nurse prescribing is likely to improve their experiences through the provision of a more effective and more person-centred service.

As well as having the potential to improve the quality of care received by patients, and the efficiency of health services delivery, nurse prescribing has also been found to be beneficial to nurses' professional development, which, in itself, is likely to be conducive to better care. Fernvall Markstedt claims that the increased competence of nurses who prescribe has been found to result in improved care for patients, including communication and access (2003). Primary care teams have also been found to benefit from the increased communication and sharing of information leading to multidisciplinary team working (Seager, 2003).

Numerous studies have found that patients approve of, and readily accept nurse prescribing (Cumberlege, 2003; Brooks et al., 2001). More importantly, patients have been found to be satisfied with the quality of care that nurse prescribers provide (Latter and Courtney, 2004; Brooks et al., 2001). A study of nurse prescribing in England found that patients valued the accessibility and approachability of nurse prescribers, which led them to discuss health issues they would not otherwise have brought to the attention of the general practitioner (Luker et al., 1998). Another study in 20 general practices in England and Wales found patients to be more satisfied with nurse practitioners consultations than those with general practitioners (Venning et al., 2000); however, reasons for this preference were not given.

The review carried out on the pilot projects ran by An Bord Altranais and the National Council for the Professional Development of Nursing and Midwifery found that the majority of patients were completely satisfied with the information provided by the nurse/midwife (2005). If other pilot studies take place as part of the process of introducing nurse prescribing, further research should be carried out to ascertain and analyse patients' views on this new development.

However, as with any new initiative that has the potential to affect people's health, its possible introduction needs to be gradual and with the appropriate monitoring and evaluation systems firmly in place prior to implementation. It is critical that drug prescribing (by any health care professional) is safe, of high quality and effective.

What health care settings, do you consider would benefit from extending prescribing authority to nurses and midwives?

Nurse prescribing has been found to increase choice, access and convenience for users. Moreover, it often leads to more timely interventions, hence preventing the exacerbation of symptoms, and usually provides easier supervision of chronic conditions (Seager, 2003).

From a primary care point of view, Seager claims that nurse prescribers allow the maximization of resources by making the best use of skill mix of the workforce. It also leads to less wastage as patients are seen and reviewed more regularly (2003). In this area it could contribute to effectively addressing many needs in the expanding area of chronic care management (e.g. diabetes, heart disease, respiratory disease, etc.). It would also work successfully in relation to women's reproductive health (e.g. antenatal care and management of menopause) and sexual health for both men and women (e.g. contraception).

In hospital settings, medical prescribing has often been found to effectively rubber-stamp the decisions made by the most experienced nurses (Ryan, 2004). Moreover, if used effectively, nurse prescribing would allow consultants to dedicate more time to more complex cases (Hennell et al., 2004). Here it could be introduced to manage selected emergencies and injuries not requiring hospital admission and also in outpatient clinics. In community settings, it could support outreach/homecare programmes, e.g. specific chronic mental health problems.

Nurse prescribing has also been found to allow for more effective health care delivery in scarcely populated, and disadvantaged areas, where doctors' recruitment and retention is often a problem (Seager, 2003). In relation to isolated and poorer areas, the Royal New Zealand College of General Practitioners called collaboration on prescribing with nurses "a necessary development" (1999).

Nurse prescribing has consistently been found to make better use of nurses' time (Lewis-Evans and Jester, 2004), and has also been suggested as a strategy to help meeting the challenges posed by the introduction of the Work Time Directive requirements (Calling Time, 2004).

With appropriate piloting and implementation frameworks, patient care seems to improve with the introduction of nurse prescribing, as described earlier. Greater access and improved communication seem to be two of the main areas positively affected by nurse prescribing. Moreover, more effective use of both patients' and nurses' time also appears to derive from this system.

Research indicates that nurse prescribing is generally introduced in one or two areas initially, evaluated and monitored before expansion. The same approach is recommended in Ireland. Nurse prescribing should be introduced initially for a limited range of clinical areas within selected settings. Whatever settings are chosen for this initial stage, this introduction should be structured, nationally coordinated and with a planned evaluation process in place.

2. What range of illnesses/health conditions do you think could be treated by nurses and midwives prescribing?

Examples of possible health conditions were also given in the previous section. Areas that have successfully piloted nurse prescribing projects are: respiratory care, diabetes care, sexual health, neonatal units and community care in general.

3. A Number of models of nurse/midwife prescribing are used internationally. These include:

(a) Independent nurse/midwife prescribing subject to scope of practice using an open formulary, OR
(b) Independent nurse/midwife prescribing subject to scope of practice using a limited formulary.

What are your views?

(a) Independent nurse/midwife prescribing subject to scope of practice using an open formulary.

Again, the models adopted, which should also include a collaborative/ supplementary prescribing model (see question 7), should be piloted. It might be better to introduce a limited formulary initially to be followed by an open formulary open completion of a pre-established training time. Alternatively, the two different models might be better suited to different settings. Either should be feasible provided that sufficient planning, training, support and monitoring are in place. The use of protocol prescribing, which was adopted in the pilot project at the GUIDE Clinic in St James' Hospital (An Bord Altranais and NCPDNM, 2005), should also be considered.

The Council does not have the necessary expertise to make rigid recommendations in this areas, but suggests that the different models suggested along with the options not mentioned, i.e. collaborative/supplementary prescribing and prescribing protocols, be piloted and reviewed in different settings to ensure the most effective and safest model is adopted in each health area.

(b) Independent nurse/midwife prescribing subject to subject to scope of practice using a limited formulary.

4. What medications (if any) should be restricted from nurses and midwives prescribing?

Please state your reasons.

The Council does not believe that any particular category should be excluded as a matter of principle. However, some drugs might be limited to consultant initiation and special attention will be necessary in relation to the prescription and dispensation of controlled substances for palliative care (Cancer Pain Release, 2001).

Clinical protocols for prescription will have to be formulated and a comprehensive Prescribers' Formulary will need to be compiled. In this regard, the difficulties and limitations encountered in the English and Scottish programmes should be noted.

5. What educational/training requirements do you consider are necessary to enable nurses/midwives to prescribe?

It is paramount that the introduction of nurse prescribing is adequately piloted and supported by a meticulously planned implementation framework. Issues of training, supervision and evaluation would need to be thoroughly evaluated. The selection process for potential nurse prescribers would need to include an assessment not only of length of service, but also of theoretical knowledge and practical experience (e.g. Advanced Nurse Practitioner could be the starting level for progression to nurse prescribing). As nurses are not originally trained to prescribe drugs, a very thorough education programme would need to be put in place, preferably at Masters Degree level, similar to the educational criteria demanded of nurse prescribing in Australia and New Zealand. A basic module in pharmacology should also be introduced in nurse training at undergraduate level. In addition nurses who engage in prescribing would need to keep up to date with research advances, clinical trials, and best practice models in general, and participate in continuing professional development as required.

6. What form of enabling environment and relationships with clinical colleagues should be ensured to maximise the effectiveness of nurse/midwife prescribing?

Power relations within health service delivery settings are also bound to be affected by the introduction of nurse prescribing, and careful examination of possible strains across and between disciplines and hierarchical structures will be required. These ramifications will also tie into a revision of the *locus* of professional liability, and related insurance coverage, which will have to be clarified before nurse prescribing is introduced. Clear lines of responsibility and reporting will have to be formulated. Moreover, specific training will be required in relation to team-working and communications, as these are not taught as part of either nursing or medical training but will be required to operate nurse prescribing effectively.

Workforce issues will need to be addressed in order to prevent staff shortages during training periods. It is also important to note that currently in this country there is a consistent difficulty with nursing staff recruitment and retention. The Work Time Directive will result in a shortage of Junior Doctors, but if nurses take on some of the remit previous carried out by junior doctors (i.e. prescribing) it will lead to additional gaps in general nursing staff. Strategic plans to fill this gap would need to be developed in tandem with any preparations for nurse prescribing

7. Have you any additional views on the plan to introduce prescriptive authority to nurses/midwives?

The Council was surprised to note the absence of the 'Collaborative/Supplementary' nurse prescribing model from the consultation. This model was the most favoured (48%) by Irish nurses and midwives consulted through a survey conducted by An Bord Altranais and the National Council for the Professional Development of Nursing and Midwifery (2005). We consider that this model would be appropriate for a number of settings and might also be beneficial as a stepping-stone towards independent prescribing in others.

Also it is paramount that any pharmacological training received by nurses and midwives does not steer them away from a holistic model and definition of nursing care (Ryan, 2004). Therefore, nurses would have to ensure that prescribing becomes an additional tool in their ability to provide a person-centred service rather than an incentive to move towards a "prescription-driven" medical model of care.

Thank you for participating in the Department of Health and Children's consultation on the extension of prescriptive authority to nurses and midwives.

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