Exploring and overcoming the barriers to Non-Medical Prescribing

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Introduction and Background
The Cumberlege Report (1986) identified that community nurses were using a lot of time waiting for prescriptions to be written by General Practitioners once they had already identified their patients’ needs (Courtney 2007). It was suggested that limited prescribing should be allowed for district nurses and health visitors, especially around long term conditions (Humphries 2002), in the context of a care plan. This was reviewed by June Crown in 1989, and test sites were set up to pilot nurse prescribing. In 1999, a further report from Crown was published which recommended that nurse prescribing be extended to other nurses in specialist roles, which was finally realised in 2001 (Courtney 2007).

In the local Trust, nurse prescribing commenced in 2003 - 2004 when four nurses completed an educational programme in that year. Since this time, a further seventeen nurses have completed the course and a prescribing lead role was established, in October 2006, to support non-medical prescribing. Supporting prescribers to ensure that they have access to the right mandatory training and updates to satisfy organisational requirements and helping them to overcome the barriers to prescribing is a well highlighted need (Hall 2005). However, setting up processes across a large organisation where the lead works only one day a week represents a challenge. This study was therefore undertaken to gain a basic understanding of the barriers to prescribing.

There has been limited research into the number of non-medical prescribers who are actually prescribing, especially with regard to mental health nurses and prescribing since its conception in 2001 (Courtney 2005). Within the field of mental health nurse prescribing, there has been a
significant increase in the number of prescribers trained, but very little research completed as to the success of incorporating prescribing into their roles and the difficulties they have faced in implementing this. Acceptance of this role for nurses has been mixed: although nurses are aware of the benefits of prescribing both for their practice and their patients, they often have reservations about both the training provided (Nolan 2000) or the need for roles to be reviewed to enable time for prescribing (McCann 2002). Research into patient views of nurse prescribing and their confidence in being treated by nurses within general medicine has been positive (Berry 2005).

**Aims and Objectives**

A management project was undertaken to explore the most helpful approaches in promoting change and introducing and embedding new roles within practice – in this case, non-medical prescribing. With the aim of working to overcome evident obstacles to the nurse prescribing role and promoting the use of prescribing skills, this involved considering the experience of current nurse prescribers within the Trust and, if now prescribing, considering what obstacles they have encountered and the supports they have been able to access and need.

**Methodology**

In providing a lead non medical prescribing role for the Trust, it is imperative to ensure good communication and sound knowledge in enabling teams to successfully implement the nurse prescribing role. There is also a need to monitor practice and to provide mandatory training, in assuring high quality practice and staff safety, as discussed within the NMC guidelines on nurse prescribing (NMC 2006).

The Department of Health recommends establishing peer supervision and providing mandatory training, both of which have been provided within the Trust in the form of two forums. However, attendance at these forums has been sporadic, although this is currently being addressed through local policy and practice development initiatives.

Considering the provision of training and the needs of the Trust’s services, it is important to explore the barriers to non-medical prescribing practice. A specific questionnaire was therefore designed to explore current
prescribing practice, barriers to prescribing and the ongoing development needs of non-medical prescribers within the Trust.

Designed to include questions informed by current practice and NMC Guidance (NMC 2006), the questionnaire was piloted for ensuring viability. Feedback on the pilot confirmed that the questionnaire was self-explanatory and easy to complete, such that it could be mailed to staff as a self-report questionnaire. An explanatory letter was enclosed to advise on confidentiality, and confirm the anonymised reporting of findings.

A questionnaire was forwarded to all 15 trained nurse prescribers in the Trust, eight of whom returned a completed questionnaire, of whom five were presently prescribing. Semi-structured interviews were subsequently conducted with the other seven nurse prescribers, only three of whom were prescribing. The findings are summarised below.

Findings

10 of the nurse prescribers completed their prescribing training in 2005; 3 in 2006; and one in 2004 & 2007 respectively.

As shown, most respondents completed their training in nurse prescribing when it was still in its infancy, and available free to both the organisation and the individual. The government agreed to open up nurse prescribing to other professional areas following a trial with district nurses and health visitors, and funding was initially made available for this (Courtney 2002). Within the Trust, a nurse prescribing conference was held in early 2005 to promote the training, and the number of staff applying for the course quickly increased. Many of the early prescribers had undertaken their training before practice support systems were in place, nominating themselves for the course. Bradley (2004) reported that those prescribers who accessed training before the organization had agreed a strategy often resulted in poor prescribing practice once qualified.

11/15 nurse prescribers reported having completed the Trust’s additional mandatory training for nurse prescribers.

The Trust began sending staff on the nurse prescribing course with little support once they had qualified, which resulted in a reactionary development of support systems and little mandatory training being
provided initially. Upon interviewing seven nurse prescribers, Lewis-Evans (2003) reported concerns about the availability of update training, to maintain their skills, and support from the organisation, that they felt they needed for satisfactorily fulfilling the role. The Trust has since been addressing these issues by introducing mandatory peer supervision on a six weekly basis and by setting guidance for mandatory additional training. The majority of nurse prescribers in the Trust subsequently completed the Trust’s mandatory training: a medication management course that focuses upon the use of psychotropic medication and practical concordance strategies; a course on physical health checks that includes history taking. The NMC (NMC 2006) has specified the development needs of nurse prescribers, which will be incorporated into the Trust’s programme of mandatory training.

10/15 nurse prescribers reported having the support of their medical supervisor.

The support of medical supervisors has been sporadic, and early indicators highlighted a lack of medical support in some teams. In fact, upon commencing nurse prescribing within the Trust, a questionnaire was forwarded to the consultants. Though only six responded, concerns were expressed about the safety of prescribing practice in mental health. Jones (2004) highlighted the concerns of medical staff as cost implications and role depreciation. In the Trust, when the conference was initially advertised, there were no representatives from the medical staff. Since this time, education and support has been provided to consultants in achieving an acceptance of nurse prescribers within their teams. However, the lack of medical support still presents a major barrier for some teams. This will need to be a priority for the future in ensuring that nurse prescribing is embedded within the Trust.

12/13 nurse prescribers reported having the support of their manager to prescribe (2/15 responded as not applicable).

The majority of the prescribers who responded had experienced support from their managers to prescribe, although it would have been useful to have identified exactly what support they were receiving. McCann (2002) explored the implications of prescribing on twenty four nurses, highlighting the need for definitive role re-structuring and management support within the teams. Humphries (2000) identified another difficulty for the prescriber, as the need for time to complete the additional documentation
that is required. Having a definite idea about how the nurse prescriber will be able to utilise this skill in each team, management support in attending forums and training, and time to complete the additional documentation, would all need to be established in ensuring that future prescribers are enabled to implement their skills in practice.

12/15 nurse prescribers last attended the Trust’s nurse prescribing forum in 2006, one in early 2007 and 2/15 stated that they had not yet attended.

The Trust’s nurse prescribing forums are aimed at providing ongoing peer support and education by the Trust’s pharmacist and interested consultants. This has been poorly attended since its conception, which may be linked to the prescriber’s view of the Trust’s desire to support and facilitate prescribing in their areas of practice. Hall (2005) identifies the organisation’s responsibility in supporting and assisting those who have completed the course to prescribe and also to receive ongoing practice development training. Nolan (2001) identified the need for more training to be available both during and following nurse prescriber training. Though there is a general request for more training among the Trust’s nurse prescribers, there is clearly a need to further explore the poor uptake of arranged forums.

7/14 nurse prescribers reported having experienced difficulties in setting up supplementary prescribing in practice.

The Trust’s non medical prescribing lead will clearly need to ensure that there processes are implemented to ensure that all prescribers can access prescriptions pads, and gain access to a locked facility for their safe-keeping. Brookes (2007) focused upon the change management process in enabling prescribers to establish and deliver new skills – the Trust will need to be vigilant in identifying difficulties to establishing prescribing practice in ensuring the commencement of prescribing practice. Jones (2005) identified the need for organisations to be clear about their strategy for implementation, ensuring that areas where prescribing practice is progressing well is developed further and replicated within similar teams.

7/15 nurse prescribers confirmed that they were presently prescribing.

Respondents reported that prescribing is helped by having a supportive and committed team, a specific service role (such as prescribing within a memory clinic, depot or denzapine clinic), having the support of a medical
supervisor, and through enhanced relationships with colleagues. A number of barriers were identified: pressure of work, an inability to agree a specific application, opposition from the consultant, being in a team manager role, the reluctance of team-members to agree to nurse prescribing, a lack of self-confidence, a lack of support, and isolation from others who support the initiative.

Relating to some of the concerns expressed by Jones (2004), many of the nurse prescribers completed the course through their self-motivation rather than as part of a Trust strategy that considered where nurse prescribing could best be implemented. Sending managers to the course is clearly an expensive option, and as the role of managers has changed within the Trust, there has been a shift away from the clinical role with no opportunities to prescribe. Knowledge of the specific barriers encountered in each team will facilitate the development of an action-plan to overcome the barriers. Since this study, nurses who are interested in undertaking the course have been asked to attend a short interview to discuss their proposal for acquiring and using prescribing skills within their practice area.

12/15 nurse prescribers reported a wish to prescribe as part of their current role following course completion.

This was a very positive response and reflected the research conducted by Hall (2005), in spite of the evident barriers to practice. Bradley (2004) found that those prescribers who were able to utilise their prescribing skills in their current roles felt more positive about prescribing and the benefits it holds for their clients. The aim will therefore be to support and encourage nurse prescribers to identify a role within their areas and to encourage them to become more motivated about taking this forward. This will be easier if a role is clearly defined at the outset.

Respondents identified a number of requests for ongoing training to ensure safe practice: continued peer support (3 responses); specific professional development courses / updates (10) e.g. physical health care, pharmacology, legal issues, policy developments; advice on medications and cautions (2); support and commitment from the team (1); regular supervision (2).

This highlights the need for more formal mandatory training, and is reflected within the NMC Guidelines (NMC 2006).
Respondents identified a number of supports that they should have put in place before starting the course that would have facilitated implementation: reading around the subject (1 response); securing support for implementation (4), from the consultant, manager and professional lead; talking to those who had completed the course (1); finding a course with a specific focus on mental health (1); establishing a role for prescribing within the practice area (1); reducing the caseload (1); considering the changing role of Team Manager (1); better understanding the role (1).

Supporting the consultants to understand the role will be important in ensuring future practice of nurse prescribing, and encouraging staff who wish to train as prescribers to thoroughly consider the role and its application within the practice area. As espoused by Courtney (2005), the introduction of the lead non-medical prescriber has enabled greater centralisation on who is prescribing and the sharing of good practice, whilst providing a much needed support and supervisory role for prescribing practice.

**Conclusion**

The number of people attending the course in the Trust has been sporadic since the outset, with no clear vision about how it was promoted, and how many should be supported onto the course. Bradley’s (2004) conclusion was that nurse prescribing should be implemented using an organisation’s strategy to see where it is working and replicating that practice. This involves setting up systems to monitor who is attending the course and how it can work in their clinical area as essential feedback on implementation and practice. Black (2007) highlights the need for everyone to be clear of their roles in a team with a clear strategy and aim to measure against. The role that the lead prescriber will play in developing nurse prescribing needs to be clear to the organisation, to enable the replication of good practice to develop.

The nurse prescribers who completed the course in the first two years were viewed by the Trust as champions for nurse prescribing, despite the generic feel of the original course and the lack of specific training during the course, such as physical health checks and mental health medication. Relevant additional courses were subsequently identified as mandatory training for all nurse prescribers in the Trust, and were written into the
organisation’s strategy, and the majority of staff have now completed this mandatory training. Templar (2005) makes it clear that an integral part of the manager’s role is ensuring that the team or workforce has the right skills for the job. The lead prescriber will need to ensure that required training is both clearly outlined and available when required.

As the support of a medical supervisor is mandatory for undertaking the course, some staff have overcome the problem of being unable to access such support from within their own team by approaching other teams, though this has caused some difficulties upon course completion. In response to the concerns expressed by medical officers, Jones (2006) suggests that nurses and consultants need to develop a different kind of relationship. In one of the Trust’s Units, the consultant has expressed concern over their diminishing role if nurses started to prescribe as well. The lead must therefore develop good communication networks with this group, as described by Brookes (2007), and be able to discuss barriers and nurse prescribing needs within the Trust with this group of staff.

Management support for prescribers in their clinical areas has been viewed positively though, as nurse prescribing becomes embedded, the role of the Team Manager will need be to more open and robust. Brookes (2007) highlights the need for change management in the clinical environment to assist with the implementation of prescribing, specifically considering the culture of the team. Nurse prescribing can present a big cultural shift for some teams, especially where there are very strong medical interventions. Identifying the culture and making steps to change needs to be led by the team manager with support from the lead prescriber in the first instance. The lead must enable teams to manage this change (Black 2007) by providing support for managers and prescribers and having clear objectives for prescribing in these teams and the Trust as a whole.

Peer support and supervision is seen as an essential component of staff support for prescribing, but attendance remains ad hoc rather than being viewed as an essential component of personal development. Brookes (2007) emphasizes the need to maintain competency in prescribing by ensuring that the organisation provides, either individually or to a group, supervision which allows prescribers to reflect on prescribing practices. Set agendas are currently in place, though these will need to be reviewed in
both forums to further reflect the needs of those prescribers attending. The lead will clearly need to encourage all the prescribers to talk about their needs and how they wish them to be met, whilst also supporting and educating them. Promoting effective forums will require all the prescribers to participate and discuss the vision, and work together to break the barriers.

This study has highlighted the need for having a clear role for prescribing in the practice area before commencing the course, rather than leaving this to the end. Having a defined role for prescribing is essential if prescribing practice is to be embedded within Trust services, which must involve discussion with the team. Hall (2005) talked about nurses owning their prescribing and allowing them the space and time to develop a role, with the support of the organisation. The lead will need to work closely with those areas where barriers are more prominent, which will include working with consultants and teams to consider ways of enabling the implementation of skills by prescribers in the team. Templar (2007) identifies the need for the manager to continually look ahead and embrace change. The lead will need to be able to embrace change and support clinical areas in developing strategies that will advance prescribing practice.

It is worth noting the initiatives that have assisted the prescriber to prescribe in replicating such practice within other teams/services. This includes: having the support of the whole team; and, planning before commencing training. Jones (2005) found that identifying clinical areas where prescribing works well is helpful for replicating good practice in similar teams. In the Trust, nurse prescribing is more prevalent and successful in the community mental health teams and in-patient rehabilitation units, such that these areas now feature in the strategy for advancing nurse prescribing over the next couple of years. Doherty (2007) suggests looking to the manager to ensure that effective communication processes are in place and the organisation is aware of the strategy.

The majority of people who have completed the course have indicated that they would still like to use their prescribing skills – a very positive finding. Bradley (2004) talked about the nurse’s confidence in their prescribing abilities as being higher when first completing the course, though falling if not going on to prescribe. In the Trust, motivation is still high, so the lead
will need to target those who are not yet prescribing. Black (2007) emphasizes the need to motivate team members, which involves sharing the vision and working with everyone involved to achieve that vision.

Continued professional development is essential, which has so far primarily been achieved through the structure of peer forums within the Trust, where training events are organized and speakers are invited. Since the publication of the NMC Guidelines (NMC 2006), an annual mandatory update for all prescribers has been arranged by the lead, to ensure that nurse prescribers are updated. Regular medication information is passed through to nurse prescribers using the e-mail facility, and the Trust’s quarterly newsletter, *Medicine Matters*, is distributed to the nurse prescribers.

Following this study, and as discussed by Jones (2005), it has been formally agreed that interviews will be held with all potential prescribers at which they will be asked to identify how prescribing would be used within their practice area, and confirming that they have the support of their line manager and consultant psychiatrist. The development of a lead nurse prescribing role for the Trust will help in supporting teams who are struggling to implement nurse prescribing and ensuring that those undertaking the course are able to gain support during their training by having an identified person to contact. The lead would need to be able understand the roles of the prescribers within their own clinical areas and, as Templar (2007) highlights, be able to negotiate changes with all parties in developing practice.

Nurse prescribing will continue to develop within the Trust, and although it has been agreed to support and progress supplementary prescribing at the present time, there is discussion about establishing and supporting independent prescribing in specific areas of practice, such as the memory clinic and sensory service. Brookes (2007) highlights some of the benefits of independent prescribing for secondary services, especially when working closely with the primary care trusts – the community mental health teams in the Trust have been considering how best to develop close links with General Practitioners. The Trust’s vision for the development of nurse prescribing must be shared within the organisation and with all nurse prescribers, in encouraging and advancing good practice.
References