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Abstract

Results are presented from an audit of mental health nurses (MHNs) who have undertaken training in order to practise as supplementary prescribers as part of an evaluation of the development of non-medical prescribing (NMP) across South West Yorkshire Mental Health Trust (SWYMHT). Quantitative (demographics) and qualitative (open-ended statements) results derived from a questionnaire survey are analysed and compared to the national picture. Implications for the governance arrangements which need to be in place for the further development of non-medical prescribing in mental health care, both for the Trust and nationally, are suggested.

Key words: Non medical prescribing; Governance; Mental Health Nursing; Audit.

Introduction

After a slow start at the end of the last century, developments in nurse prescribing in the United Kingdom (UK) have moved swiftly over recent years (for a history of NMP see Mills 2008). There are now over 600 out of approximately 10,000 Mental Health Nurses (MHNs), who have been trained as independent and supplementary prescribers (Brimblecombe, 2007). Having undertaken a 27 day theoretical, University, minimum degree level course, as well as 12 days of medical mentoring (NPC et al 2005) these MHNs can potentially prescribe any drug from the British National Formulary (BNF). In mental health, national guidance regarding the implementation of MHN prescribing has signalled Government support for these developments (NPC et al 2005). The Chief Nursing Officer's review of mental health nursing also identified the importance of this developing role for MHN's in making a difference within services (Department of Health 2006, 2007). There is now some published evidence describing the development of prescribing by MHNs (Grant, et al 2006, Jones & Jones, 2007; Hemingway & Harris, 2006; Wix, 2007; Norman et al 2007). However despite this national emphasis and a growing evidence base for the benefits of MHN prescribing, the national picture is one of seemingly piecemeal and patchy implementation with significant numbers of trained MNH prescribers in some areas of the country and very few in others (NPC et al 2005).

Despite the evidence that prescribing by MHNs is developing across a wide range of mental health specialties, and the positive news that MHN prescribing has been evaluated safely (Norman et al, 2007), the reality remains its implementation by mental health trusts has been sporadic (Bradley et al., 2008). In 2004, four trusts had 81% of the MHN prescribers who had completed their training (NPC et al 2005: Murray, 2007). This does not reflect the UK as a whole where the planning and implementation of MHN prescribing has appeared more opportunistic and haphazard (Mazhindu & Brownshill, 2003; NPC et al 2005). MHNs have potentially been trained to prescribe without governance procedures in place for them

to practice, or a clear strategy to support the implementation of their new role, with one study sample showing that only 51% of MHNs trained were actually practicing as prescribers (Grey et al., 2005). In comparison to general adult nursing practice, where nurse prescribing is often well established, prescribing implementation by mental health trusts appears to be far more cautious and thus the roll out of nurse prescribing appears to be slow (NPC et al., 2005: DH, Bradley et al 2008). This is despite the proposal by both the England and Scotland reviews of mental health nursing that non medical prescribing is central to MHN's improving their contribution to service user recovery (Department of Health, 2007; Snowden 2007):

> Indeed Recommendation 13 of Values to Action stated:
>
> 'Service providers are to put in place arrangements to support the implementation of nurse prescribing, based on local need, taking into account the potential for service redesign and skill mix review, using both supplementary and independent using both supplementary and independent prescribing arrangements" (Department of Health 2007)'.

Set against the national picture where there are clear policy directives to support MHN prescribing, it was decided to conduct an audit of current non-medical prescribing activity across SWYMHT. The audit was co-ordinated by the Trust NMP steering group which commissioned the Trust's clinical governance and support team to evaluate the impact of non medical prescribing to date across the Trust. The Trust implemented a framework for non medical prescribing in May 2005, which identified the governance and procedures for staff undertaking supplementary non medical prescribing. This detailed framework includes: a pathway for the identification and approval of staff undertaking non medical prescriber training, the process of induction for newly qualified non medical prescribers and the continued professional development (CPD) strategy for clinicians undertaking this area of practice. The first stage of this audit was completed in late 2007 and provided an indication as to the effectiveness of the Trust governance arrangements for NMP.

Background

The Trust introduced supplementary prescribing in June 2005. The Department of Health (2004b) defines supplementary prescribing as

> "A voluntary partnership between an Independent Prescriber (a doctor or dentist) and a Supplementary Prescriber to implement an agreed patient specific Clinical Management Plan (CMP) with the Patient's agreement." .

Supplementary prescribing, with the agreement of service users, enables nurses, pharmacists and allied health professionals to prescribe and make adjustments to medication based on agreed clinical management plans. This facilitates a more flexible approach to care delivery and the development of professional roles.

Supplementary prescribing is underpinned by the following key principles:

- That the service user is treated as a partner in their care and is involved at all stages in decision making, including whether part of their care is delivered via supplementary prescribing.

- The importance of communication between the prescribing partners.

- The need to access shared service user records.

Aim and Objectives

The stated aim of the overall audit project was to evaluate the impact of NMP in the Trust with the following objectives:

- To ascertain prescribing activity and views of the qualified NMP.

- To audit the clinical management plans (CMP).

- To ascertain service users and carers views of their experience of the NMP service.

This paper presents the results of the first stage of the audit in identifying current prescribing activity and eliciting the views of qualified non medical prescribers employed within the Trust.

Methodology

An audit steering group was established with members from the Trust's NMP steering group and clinical governance and support team (CGST) The Chief Pharmacist provided a list of the current qualified NMPs, from a database maintained on behalf of the NMP steering group.

Survey Questionnaire

A 24-item survey questionnaire was developed. The survey consisted of open and closed questions focussing on demographic details of the respondent NMPs (3 items) as well as specific questions designed to elicit if they are actively prescribing and how many times per week (4 items). Also, examples of CPD activities were requested (2 items). The experiences and views of respondents since qualifying as a prescriber and how this has impacted on clinical practice in terms of their role and outcome for the service user were also sought. In addition, an open ended part of these questions invited respondents to describe examples of their experiences since undertaking the course (14 items). Finally one item contained a section to describe any further comments.

The Clinical Governance Support Team e-mailed the survey to all prescribers for return either electronically or as a hard copy. The surveys were anonymised. A repeat electronic questionnaire was sent as a reminder and followed up by a posted hard copy, to maximise opportunity for qualified Trust non medical prescribers to respond.

Results

Response Rate and Demography

A total of fifteen questionnaires were emailed to the non-medical prescribers (NMP) of which nine (60%) were completed and returned to the CGST.

Respondents were asked if they were currently prescribing of which three (33%) stated they were, with six not prescribing at the time of audit. It was not clear why there had been such a small return from the pool of practising MHN prescribers within the Trust. In looking at the small number who actually were prescribing this is not unusual. Evidence from a UK study has shown that only 51% of MHNs who had undertaken the appropriate training had begun prescribing up to one year post qualification (Gray et al 2005). Secondly a study from the US reported that 18 months following completion of appropriate training only 40% of MHN's were practising as prescribers (Kaas et al 1998).

Respondent Characteristics

The three prescribing MHNs had all been qualified nurses for over 15 years, these respondents were working in either adult mental health or older people's mental health teams (OPMH). One had been qualified as a NMP for less than a year, one for 1-2 years and one for 2-3 years. Of the six MHNs (67%) not currently prescribing five had been qualified nurses for over 15 years and one for 6-10 years. Hemingway (2005) and Hemingway and Harris (2006) found experience to be a key factor as to whether MHNs developed toward prescribing.

Reasons for not Prescribing

Five respondents gave the following reasons for not prescribing.   A key reason stated was for the necessary structures to be in place to enable them to prescribe:

> "Awaiting registration to be processed from NMC."

> "Awaiting medics to commence with the team. Once this is in place will be looking into implementing with immediate effect."

> "Need for cross boundary agreement with (acute) Trust."

Whilst another reply showed a more concerning aspect:

> "Since qualifying no support, feels like left to fend for self. Tried to get going - still waiting for contact, having asked for help."

An absence of need within the service structure was also identified as a barrier by one respondent:

> "Following new ways of working there are usually doctors available to prescribe."

Bailey and Hemingway (2006) highlight inter and intra professional variables that affect the MHNs development toward prescribing. Clearly in this example, professional variables are seen by the respondent as a key factor that has prevented them from prescribing. Bradley et al (2008) particularly draw attention to the need to appropriately plan how the new MHN prescriber will develop their role within service configurations.

Frequency of Prescribing

One NMP prescribed 1-3 times per week and issues an average of 12 prescriptions per month, and one prescribed less than once per week and issued an average of two prescriptions per month. The third prescribed less frequently due to a reported "influx of doctors has created a challenge." During the early stages of developing this role following qualification, prescribing in a limited fashion has been described as an ideal way for the MHN to gain confidence in undertaking prescribing activity before developing competently with a wider prescribing portfolio (Bailey 1999, NPC et al 2005). As NMP becomes more prevalent in the Trusts future business and service development plans it will be of interest to audit the type and scope of prescribing activity to map how this has developed.

Continuous Professional Development (CPD)

CPD is a very topical issue for the development of nurses as prescribers. Criticism has been levelled toward nurses' for having an insufficient knowledge of pharmacology and medicines management in relation to prescribing (Avery and Pringle 2005, Cressey 2007). Alongside this there have been questions as to whether the generic prescribing course curriculum adequately prepares the MHN for prescribing practice (Bailey and Hemingway 2006, Bradley et al 2008). Therefore CPD activity is an important issue for MHN's in developing and sustaining competence as prescribers.

Results from the two CPD response questions showed respondents were satisfied with the CPD updates they had received in the last year (very satisfied = 2, satisfied = 7).

Respondents were asked to indicate which CPD activities they had accessed. All nine NMPs had attended education events organised by a regional good practice network for non medical prescribing and medication management in mental health (M62 Network), and six had attended a Trust Medicines Management Update. Two had completed a local University Medicines Management and Psychiatry Module. One had attended pharmaceutical company drug representative updates and one described the use of internal networking for CPD.

Comments displayed agreement with the need for CPD activity:

> "Safe ideas, experiences, keep up to date."

> "As this is a period of development and change and not always consistent approach in every trust it is important to have information on a regular basis."

About the difficulty of attending CPD:

> "Often hard to attend due to time constraints and mandatory/NMC training CPD."

And with one appearing to questioning the usefulness of available CPD:

> "Lot of meetings feel like lip service."

CPD Opportunities

Respondents were asked if there were any other CPD updates that would be beneficial to them.

> "Would like to tie into the journal clubs used by the medical staff."

Some respondents identified a need for more formal education:

> "Psychopharmacology modules."

> "Psychiatric medication."

One seemed satisfied with the present arrangements, perhaps reflecting on the pressure on time to undertake such activity:

> "I think there are sufficient events currently."

Impact of NMP Training

The NMP course is designed to facilitate existing experiential knowledge of medicines toward the student being able to prescribe competently within their own scope of practice. This is supplemented in the clinical supervision sessions with the medical mentor. The student then prepares for practice (Bailey and Hemingway 2006).

Respondents were asked whether developing as a prescriber has had an impact on their knowledge of medicines and their interactions.

Six respondents said that prescribing activity has increased their knowledge of medicines (current prescribers = 2, not currently prescribing = 4), and one prescriber said it had not increased their knowledge. Two did not answer the question.

Two currently prescribing commented. Firstly on their use of information resources:

> "Always use BNF and Maudsley prescribing guidelines."

And, how the course facilitated their development in this aspect of prescribing:

> "In becoming qualified to prescribe I became more aware and informed of the broader picture of prescribing and my accountabilities."

Four currently not prescribing commented, indicating that they anticipate development with regard their knowledge of medicines:

> "I'm sure it will when I commence prescribing."

How the course has facilitated their knowledge:

> "Now more aware of side effects and how medication interacts with the body."

One described how they stayed motivated:

> "Despite not prescribing have kept interest."

And the need to keep updated:

> "Have not prescribed but being a prescriber requires regular self directed update re BNF and research articles."

Adverse Drug Reactions

Intolerable side effects are a major reason why the service user discontinues taking psychotropic medication with a subsequent high chance of relapse (NPC et al (2005). Therefore, if the NMP is to have an impact this is one of the outcomes that would need addressing. Six respondents reported that developing toward prescribing practice had increased their knowledge of adverse drug reactions (current prescribers = 2, not currently prescribing = 4), and one prescriber said it hadn't increased knowledge. Two did not answer the question.

Two currently prescribing commented. One described how they seek to be competent in this area as well as the service as a whole.

> "Yes, discuss with Dr X, psychiatrist and research if unsure about adverse reactions. Carried out training for other staff."

With the reminder that developing as a prescriber brings responsibilities:

> "Again I need to be aware of adverse drug reactions due to my accountability."

Two not currently prescribing commented that actively prescribing will highlight the need to be able to assess and take appropriate treatment strategies:

> "I'm sure it will when I commence prescribing."

> "More alert to possible side effects and how to report."

Autonomous Practice

Prescribing has been described as an advanced practice activity (Bailey and Hemingway 2006). To be an effective prescriber and to be able to take decisions as necessary, the nurse needs to be able to work autonomously (NPC et al 2005).

The three current prescribers said that prescribing had increased their level of autonomous practice, and two made the following comments.

That prescribing needs to be seen within a systems approach:

> "It will do, but it also makes you aware of the need to act as a team to ensure all prescribers are aware of your prescriptions."

One respondent's prescribing practice seemingly had not developed particularly autonomously.

> "Mainly repeat prescriptions."

Of the six currently not prescribing two reported it had increased their autonomous practice and one gave an example of how it has empowered their practice:

> "Confidence in giving advice to acute hospital staff."

Workload Issues

Before the MHN attends the prescribing course, planning and establishment of how this will impact on their role should be part of the governance in place (NPC et al 2005, Bradley et al 2008). Failure to do so negates the expensive process of training the MHN as an NMP and leads to a lack of confidence and motivation for the MHN who has invested so much into this new role. However four respondents said that NMP has an impact on their workload and positively made the following comments:

That it has and will lead to practice more focussed toward prescribing:

> "Yes, tend to accept cases that are suitable for non medical prescribing." (current prescriber)

> "I anticipate it will do. I will be cross-working with more patients whilst maintaining my caseload." (current prescriber)

And that they feel that their practice will change:

> "Due to training yes but unsure until start prescribing." (not currently prescribing)

Impact of NMP for Service Users

The whole purpose of the development of non medical prescribing is to improve the prescribing service outcomes available for the service use and to make this service more accessible at the time of need (NPC et al 2005). The respondents were asked their views about the impact of NMP on their ability to improve their medicines management interventions for service users, and the responses are presented in the following four categories

1. Medicines Management

Five felt that NMP had increased their skills in effective medicines management with service users. Three made the following positive comments.

> "Yes as I try to involve service users and give relevant easy to understand information and promote concordance." (current prescriber)

> "I am now more aware of the wider range of experiences that influence a patients' behaviour in taking, or not taking medication." (current prescriber)

> "I pay more attention to medicine management than I did prior to the course." (not currently prescribing)

2. Improvement in Care Provision?

When asked if prescribing activities had positively improved the care they provide for service users, seven respondents reported that it had. When asked to give examples five made the following comments:

> "Again, I anticipate it will. This is particularly with regard to out of hours access to medication and Trust in what is being prescribed." (current prescriber)

> "Earlier access to medicines." (current prescriber)

> "Yes, able to provide prescriptions and provide or adjust medication sooner." (current prescriber)

> "Can give an up to date knowledge of psychiatric medication to acute hospital patients." (not currently prescribing)

> "I think I provide a more rounded service than previously." (not currently prescribing)

> "It would if I were prescribing." (not currently prescribing)

3. Service User Choice

Seven respondents identified that NMP improves service user choice. Four made the following comments.

That it can have an immediate positive impact:

> "Yes as able to spend more time with service users and carers and adjust medication to suit their lifestyle, and to monitor side effects and adjust quicker." (current prescriber)

And that MHNs not yet practising as prescribers can see positive benefits in the change in service:

> "Not had direct feedback as not currently prescribing but I think some service users feel more able to negotiate with the person who regularly see's them" (not currently prescribing)".

> "I am able to describe alternative medication and treatments to service users." (not currently prescribing)".

> "It is easier for clients to make an informed choice when medical treatment is part of a care plan which is comprehensive e.g. includes education re illness and not seen as something that happens in isolation at out-patient appointments." (not currently prescribing)".

4. Access to Medications

Five respondents thought that medicines access is easier for service users where NMP is in place. Five made the following comments.

As part of the changed service involving MHNs as prescribers:

> "Yes as often they will not attend out patient clinic or GP surgery." (current prescriber)".

> "Access is improved not only in ease of access, but also in the patient actually initiating access and requesting help by speaking more openly to a trusted worker rather than an unknown GP out-of-hours." (current prescriber)".

That it will improve the service that can be provided:

> "Offers a more flexible approach as team operate out of hours." (not currently prescribing)".

But that only being able to practice as a supplementary prescriber will be restrictive on the MHN being able to make easier access to medicines achievable for service users:

> "Not in my case as I am not currently prescribing. Independent prescribing would make access to medication easier for service users." (not currently prescribing)".

> Yes if CMP but still has limits as independent prescribing would certainly provide easier access." (not currently prescribing)".

Prescribers Views of NMP

Respondents were asked how confident did they feel as a nurse prescriber, of which all three current prescribers felt quite confident. When asked to further explain their confidence one respondent commented :

> "Quite confident but will be prescribing from a limited range until my confidence increases."

Of the six not currently prescribing, three felt quite confident and made the following realistic comments.

> "Due to not prescribing I am a little wary but I am aware of the theory and where to look and have supportive colleagues and will only prescribe if confident."

> "Having not prescribed in the time since registration I would need to revise procedures to feel very confident."

Two reported not feeling very confident and one not at all confident due to not prescribing. These comments echo Kaas et al's (2004) findings that the longer the time it takes for the nurse to start prescribing the more marked effect:

> "Due to not prescribing, but may feel worse if I do prescribe."

> "This is because I am not actually prescribing."

> "All confidence gone."

Positive Aspects of NMP

Respondents were asked what they thought were the most positive aspects of NMP. Most reasons given were around speedier access to medication and benefits to the service user. The answers shown in these respondent's views can be seen to fit well with national guidance describing the potential improvement in service provision available and better use of nurse's skill and knowledge through the implementation of NMP (NPC et al 2005).

> "Earlier access to medication. " (current prescriber).

> "Able to respond quicker to individuals needs. Good working relationship with independent prescriber." (current prescriber).

> "Timely access to medications for the service user and the time saved for the nurse who previously had to chase a doctor, potentially for several hours if working out of hours." (current prescriber).

> "Benefits to clients and staff being a resource for information and actual prescribing and can prove helpful to some clients not to see a number of different professionals in a short space of time." (not currently prescribing).

"More flexibility for service user, more choice as to who the service user wants to discuss such issues with. Can be addressed quicker and prescription issued quicker." (not currently prescribing).

"Within my line of work…. it is often easier for the CPN nurse prescriber to introduce medication as a therapeutic relationship develops - rather than taking them all to out patients appointments at a psychiatric unit - which can still be a frightening place for both young clients and parents." (not currently prescribing) .

Two said that NMP had increased their knowledge and confidence.

"Increase in knowledge, skills and confidence." (not currently prescribing).

"Increased knowledge and pharmacology and safe medicine management." (not currently prescribing).

Negative Aspects

With any change in service provision (intrapersonal), and practice (interpersonal) there are potential pitfalls and barriers to overcome particularly when it involves the prescribing of medicines (Bradley et al 2008).

Respondents gave a number of intra and interpersonal aspects they felt were negative:

"Risk of litigation." (current prescriber).

"Getting access to medical records." (current prescriber).

"Actually negotiating the opportunity to prescribe when working in an area where there are several doctors practicing." (current prescriber).

"Only able to be a supplementary prescribing in this Trust." (not currently prescribing).

"Have to have CMP that tries to cover the majority of medications you think you might need to prescribe." (not currently prescribing).

"Political issues re funding medication. E.g. Mental Health Trusts or PCTs in my area of work this could be either - but I have been told to be careful not to run up increase in PCT budget." (not currently prescribing).

"Lack of confidence in myself." (not currently prescribing).

"Poor support." (not currently prescribing).

"That I am not actually prescribing." (not currently prescribing).

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Four respondents made the following general comments.

That they were restricted by the current Trust NMP framework which currently only supports supplementary practice:

> "I feel that Independent Nurse Prescribing would best suit my working practice." (current prescriber)".

> "Supplementary prescribing does not particularly fit with the service for which I work. Perhaps independent prescribing would lead to improvements for service users." (not currently prescribing).

> "I do find it difficult to be proactive in pushing forward nurse prescribing within my area because I am so busy. The preparation of GPs and consultant psychiatrists is a time consuming business as are clinical management plans. I realise these are early days - but independent non-medical prescribing is a positive step in the right direction." (not currently prescribing).

And that that remuneration issues may be one barrier for the MHN to adopt prescriptive authority:

> "Should non medical prescribing offer financial rewards in terms of salary band?" (not currently prescribing).

Conclusions

Of the respondents for this audit, the majority were not yet prescribing. It was not clear why only a minority of practising non medical prescribers within the Trust had responded, while a greater proportion of those not yet prescribing had replied. This group were generally able to identify a range of benefits for their own development and practice from having completed their prescriber training and additionally identified that opportunities for CPD were mostly useful and adequate. The need for non medical prescribers in mental health to have a robust understanding of psychotropic medication has been identified as essential. This enables confident shared working with service users to enable effective choice in shared treatment decisions (Robson & Gray 2007). The group were able to identify a range of benefits for service users including improved and faster access to medication and the potential for the non medical prescriber to offer improved choice from a range of interventions including the prescribing of medication. These responses mirror the identified benefits of non medical prescribing in national policy documents (Department of Health 2004b, NPC et al 2005, DH 2006a & 2006b).

The audit has highlighted the concerns of a number of respondents that their confidence in prescribing practice is or may be diminished by delay in the opportunity to actually prescribe following qualification. Some respondents additionally identified that independent NMP (rather than supplementary) may be more feasible, useful and appropriate for their areas of practice. The audit identified barriers to the implementation of supplementary prescribing in practice which included issues of time, presence of other (medical) prescribers within teams, reduced confidence,

fear of litigation, budgetary concerns and the lack of established cross boundary agreements between health care organisations. Hemingway (2005) and Bradley et al (2008) have identified the need for key organisational and support structures to be in place within mental health organisations to facilitate the effective and confident implementation of non medical prescribing. There is a clear need for MHN to receive adequate ongoing support in effectively implementing this new practice role within services (Murray 2007). Jones et al (2007) have previously identified that a lack of experience, shortfalls in supervisory arrangements and inadequate service redesign are all clear potential barriers to the effective implementation of non medical prescribing in mental health. For the Trust to successfully roll out non-medical prescribing it will be necessary to make the macro governance structures in place fit the micro context of clinical reality.

Actions Arising from the First Stage of the Trust Audit

The Trust non medical prescribing steering group is currently reviewing the results of this initial stage of the audit, with a particular focus on barriers to existing non medical prescribers in moving on to prescribing practice. Of the 15 MHNs who had completed prescriber training at the time of the audit, 10 (75%) are now practising as prescribers. The existing Trust NMP framework aims to set out clear processes for supporting prospective prescribers by ensuring managerial and service support is in place, including; access to appropriate prescribing budgets, independent medical prescribers and opportunities to utilise the qualification in practice. Formal requirements for attendance at CPD events are in place and CPD activity is audited and recorded annually for each non medical prescriber. The adequacy of these arrangements will now require review in light of the barriers and concerns raised by respondents. There is a clear need for ongoing work in ensuring that models of service re-design and business planning clearly include the development of NMP roles, to ensure this area of practice is clearly commissioned and forms a core element of provided mental health services.

The second stage of the audit is now planned to review completed and anonymised CMPs from practicing non medical prescribers in the Trust, to identify compliance with legal and policy requirements for the CMP. The third and potentially most informative stage of the audit will comprise of a service user evaluation of non medical prescribing.

The steering group are hopeful that the current planned development and implementation of Independent Prescribing within the Trust will additionally create greater choice of appropriate non medical prescribing mechanisms for Trust NMPs.

Limitations

Due to the small number of respondents in this local audit, the results presented in this article cannot be claimed in any way to be generalisable. The use of a survey questionnaire format limits the scope for a more in depth evaluation of non medical prescribing activity across the trust, such as could be provided by individual interviews. Despite these evident limitations, the results of the audit do in many ways appear to reflect the

reported national experiences of MHNs undertaking prescribing and have enabled a critical evaluation of how the Trust can improve the necessary development plans and governance arrangements to facilitate the effective further development on mental health nurse prescribing.

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