

# The expanding role of nurse prescribers

ANGELA DOWDEN

**Since the first legislation back in the 1980s, UK nurses have earned increasing powers to prescribe. This article discusses the scope and limitations of nurses' prescribing role now and in the future.**



**F**or a decade now, nurses with the appropriate additional qualifications have been legally allowed to prescribe any licensed drug from the *BNF* within their area of competence. However, reaching this point was neither smooth nor swift. It was back in 1986 that Conservative party politician, Baroness Julia Cumberlege, first recommended

that community nurses prescribe from a limited drug list, but it was not until 2006 that nurses – after much lobbying and a multitude of incremental stages – were allowed to prescribe from a full remit of licensed medicines.

Further changes to legislation – in September 2009 allowing nurses to prescribe unlicensed medicines and in April 2012 enabling them to prescribe virtually any controlled drug – has bestowed upon the UK nursing profession greater prescribing powers than virtually anywhere else in the world.

Figures from the National Nursing and Midwifery Council (NMC) – correct as of 1 April 2016 – record a total of 73,804 qualified nurse (including midwife) prescribers on the register, which represents 10.7 per cent of the total work force.

## Training

Nurse prescribers can be split into three categories based on how they are prescribing: independent prescribers prescribe any medicine from the *BNF* on their own initiative (within their area of competence); supplementary prescribers prescribe any medicine from the *BNF* within the framework of a patient-specific clinical management plan agreed with a doctor; while community practitioner nurse prescribers prescribe independently, but from a limited formulary (see Table 1).

To train to prescribe from the whole UK formulary, a nurse must be deemed competent to do so by their employer and have at least three years' experience after qualifying. The year immediately preceding application to the programme must have been in the clinical field in which the candidate intends to prescribe, eg mental health or neonatal medicine. The current qualification, known as V300, typically involves 26 taught days, plus 12 learning in practice days over approxi-

mately six months, and is a joint one that qualifies nurses for both independent and supplementary prescribing. It has superseded an older V200 programme, which gave nurses freedom to prescribe from an extended, and later, full formulary, but only as an independent, not a supplementary, prescriber.

For nurses who work in community care, training to prescribe only from the *Nurse Prescribers' Formulary for Community Practitioners* involves undertaking either a V100 or V150-recognised course, typically comprising 10 taught and 10 supervised practice days for

V150, or four taught and one exam day for V100.

### Benefits of nurse prescribing

According to Dr Barbara Stuttle, CBE, chairman of the Association for Prescribers, which campaigns for and promotes the role of nurse prescribing, nonmedical prescribing has been the most important development in nursing since it became a profession. "It has allowed the development of new nursing roles, allowed genuine autonomy, and benefited both services and the patients we care for, by allowing better access to

medicines and smoother services delivered," she says.

The theory is that patients will experience less delay in receiving medicines, a reduction in the number of unnecessary appointments, and have a reduced risk of hospitalisation and a faster recovery.

Without doubt, nurse prescribing also gives value for money. Indeed, non-medical prescribers are saving the NHS in England an estimated annual £777 million, according to a December 2015 report commissioned by NHS Health Education North West.<sup>1</sup> According to the report, this could be increased further by

Type of nurse prescriber	Can prescribe any licensed/unlicensed medicine, food, drug, toiletry or cosmetic?	Can prescribe appliances or reagents?	Notes
<i>Nurse independent prescribers</i> (could be nurse or midwife in a primary care or hospital setting)	Yes (except products listed in Part XVIII A of the <i>Drug Tariff</i> *) within their level of experience and competence. Can also prescribe items in the Selected List Scheme (Part XVIII B of the <i>Drug Tariff</i> *) within their competence and any Schedule 2, 3, 4 or 5 controlled drug (except for diamorphine, dipipanone or cocaine for the treatment of addiction)	Yes – any that are listed in Part IX of the <i>Drug Tariff</i> *	Pharmacists, optometrists, chiropractors, podiatrists, physiotherapists and therapeutic radiographers can also qualify as independent prescribers, but may be subject to slightly different rules
<i>Community practitioner nurse prescribers</i> (could be health visitor or school nurse, for example)	No – can only prescribe products included in the <i>Nurse Prescribers' Formulary for Community Practitioners</i> (Part XVII B(i) of the <i>Drug Tariff</i> *; largely wound care products, emollients and constipation medication)	Yes – any that are listed in Part IX of the <i>Drug Tariff</i> *. (In the <i>Scottish Drug Tariff</i> , appliances and reagents that may not be prescribed by nurses are annotated Nx)	Community prescribers are also subject to a number of extra restrictions, eg they can only prescribe paracetamol 500mg tablets in quantities up to 100
<i>Supplementary prescribers</i> (could be nurse or midwife in a primary care or hospital setting)	Yes (except products listed in Part XVIII A of the <i>Drug Tariff</i> *) but only as agreed by patient and doctor as part of a patient's clinical management plan. Can also prescribe items in the Selected List Scheme (Part XVIII B of the <i>Drug Tariff</i> *) within their competence and any Schedule 2, 3, 4 or 5 controlled drug (except diamorphine, dipipanone or cocaine for the treatment of addiction)	Yes – any that are listed in Part IX of the <i>Drug Tariff</i> *	The allied health professions mentioned above can also be supplementary prescribers, along with diagnostic radiographers and dietitians. They may be subject to slightly different rules

**Table 1.** Types of nurse prescriber and what they can prescribe. \*Reference is to English and Welsh *Drug Tariff* throughout. Section names are different in Northern Ireland and Scottish tariffs

at least £270 million a year if the quarter of most challenged GP practices in England that do not have nurse prescribers were to employ them.

Evidence suggests that the standard of care provided by nurse prescribers is as high as traditional models of care.<sup>2</sup> Patients report high levels of satisfaction with, and confidence in, nurse prescribers due to their level of specialist knowledge, experience with specific treatments and recognition of their own limitations.

Despite the documented benefits, a secondary analysis of a national primary care prescription database revealed that the number of items prescribed by nurses in primary care in 2010 was only 1.5 per cent of the total<sup>3</sup> (although this may be higher now). Nurse independent prescribers contributed most towards prescribing emergency contraception, and community practitioner nurse prescribers mainly contributed to prescriptions for dressings, stockings and incontinence appliances.

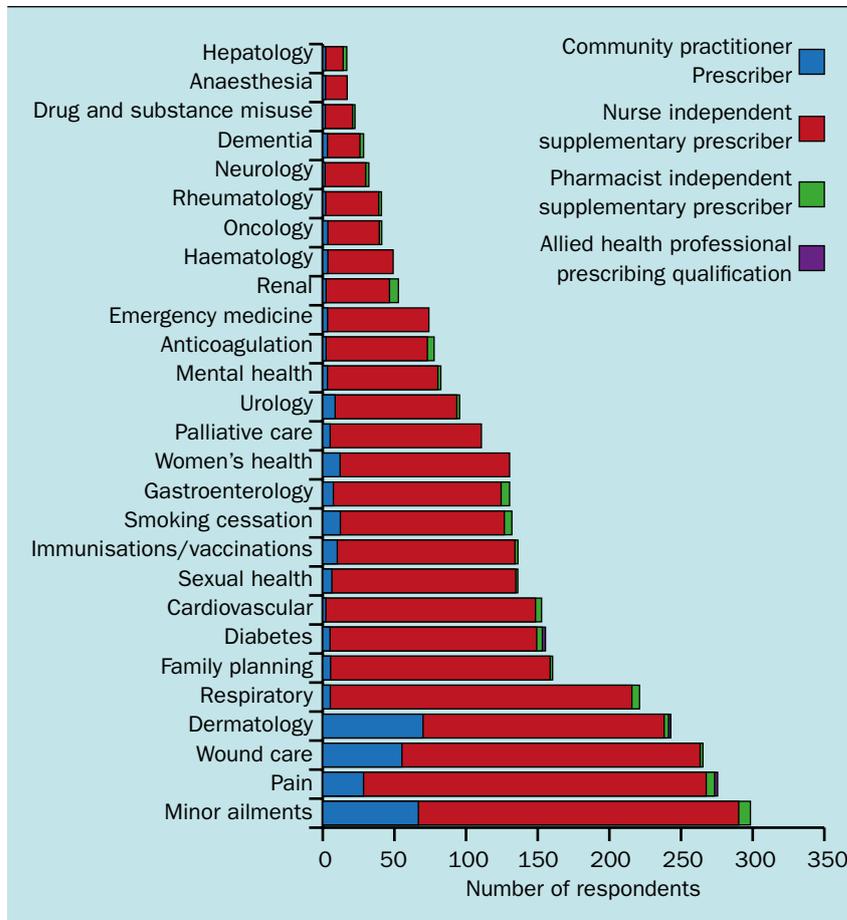
However, Professor Molly Courtenay, who specialises in research into prescribing by nonmedical health professionals at Cardiff University's School of Healthcare Sciences, says her research<sup>4</sup> suggests that nurses with the appropriate (V300) independent/supplementary qualification are usually actively prescribing. "Around 90 per cent of these nurses prescribe, the majority independently," she notes.

Moreover, nurse prescribing is not just about sending a patient, FP10 in hand, to the pharmacy and there are many other ways that nurses can, and do, use their prescribing qualification (see Figure 1).

### Barriers to prescribing

But in cases where nurses are not using their prescribing powers freely or confidently, what are the factors that prevent them? One reason may be that nurses can feel overburdened by the responsibility – 13 out of 14 nurse independent prescribers interviewed said additional responsibilities and a lack of financial reward were disincentives to prescribing.<sup>5</sup>

The Royal College of Nursing suggests that some NHS Trusts have local policies that restrict nurse prescribing based on settings, eg emergency departments, or having to work within a Trust's local formulary.<sup>6</sup> Other occasionally noted



**Figure 1.** Therapy areas in which nonmedical prescribers use their qualification. (Includes all nonmedical prescribers but 95 per cent were nurse prescribers and just 5 per cent were pharmacist and other prescribers.) Reproduced from Courtenay M, et al.<sup>4</sup>

reasons for not prescribing include procedural delays, eg lack of electronic prescribing and access to patient notes, lack of support from employers and managers, and lack of continuing professional development (CPD).<sup>4</sup>

For community practitioners specifically (with V100 or V150 registration), the limitations placed on them by a restricted formulary (largely just dressings, creams and appliances), which is widely regarded as no longer appropriate to the day-to-day needs of nurses or patients, could explain why about a third of this group are not putting their qualification into practice.<sup>4</sup>

"The role of the community practitioner has changed since the medicines listed in the *Nurse Prescribers' Formulary for Community Practitioners* were put together and the list is no longer fit for purpose," asserts Professor Courtenay.

However, these limitations look set to change, as Professor Courtenay chairs a group called the Nurse Prescribers Advisory Group for the BNF, which is shortly to review the community practitioner formulary.

### Relationship with the medical profession

When nonmedical prescribing first started, the medical profession overall was strongly opposed, citing concerns around the clinical assessment abilities and diagnostic skills of nurses. However, according to the Royal College of Nurses, these initial objections from medical health professionals have abated over the years "as evidence of improvements in access, patient safety and patient-centred care continue to strengthen the foundations underpinning nurse prescribing."<sup>6</sup>

The current available evidence suggests that doctors are confident in the skills of the nurse prescribers with whom they work, says Professor Courtenay, adding that “doctors, in their role as designated medical practitioner, are responsible for assessing the competencies of nurse prescribers.”

Working as part of the Hospital at Night team at Perth Royal Infirmary, NHS Tayside Trust, senior nurse practitioner Robyn Young says that she prescribes constantly through her shifts and that prescribing is now an essential and absolutely integral part of her role. “My medical colleagues have always been supportive. In turn, I support their junior colleagues with their clinical decision making and prescribing,” she adds.

Nurse prescribers working in primary care can feel equally empowered, as Fiona Legett, who works as practice nurse at Somerford Grove Practice, City and Hackney CCG, explains. “Becoming a nurse independent/supplementary prescriber has transformed my working life,” she says. “It enables me to initiate and titrate medication on a completely independent level, which I do for my patients with long-term conditions such as diabetes and hypertension as well as for patients who want to start contraception. Prior to my being a prescriber, patients had to wait for the GP to write the prescription, which was not time efficient for them or the GP.”

However, the response was not as positive from all nurse prescribers. Though all were glad to have done the qualification, some who communicated anonymously with *Prescriber* spoke of time-strapped designated medical practitioners unable to give enough time to their mentees, courses not well run, and not feeling well supported by the medical profession in using the qualification.

### The future

Overall, the future for nurse prescribing looks relatively bright, though this will depend on adequate funding for both initial prescriber training and CPD beyond. One obvious gap that exists is in the adult social care setting, where care homes could benefit from prescribers, yet lack of funding and training opportunities, plus no established protocol, mean that nurses are currently unable to upskill to become prescribers in the same way that NHS nurses can.

But for nurses able to embrace the autonomy and challenge, nurse prescribing can be combined with other advanced training specialisms to carve out interesting and varied roles. Natali Kelly, a nurse independent prescriber who runs her own private aesthetic clinic says: “I can prescribe antibiotics or medium-depth peels for acne, inject Botox for cosmetic purposes or for sweating and tooth grinding, and offer many specialised aesthetic

treatments to the highest standard without having a doctor on site.”

It is this blurring of lines between advanced nurse practitioner/prescriber roles and the medical profession that looks set to continue in the future, likely causing assent and dissent in equal measure along the way. As they increasingly upskill and specialise, nurses are looking more like doctors than ever before.

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### Declaration of interests

None to declare.

*Angela Dowden is a freelance journalist and registered nutritionist*