

## Nurse prescribers: who are they and how do they perceive their role?

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**Nurse prescribers: who are they and how do they perceive their role?**

**Aims.** This paper reports a study to elicit background data from recently qualified nurse prescribers and explore aspects of their work.

**Background.** Nurse prescribing has been introduced quite recently in the United Kingdom. Although a certain amount of information is available about the characteristics of nurse prescribers, relatively little is known about their professional backgrounds, their reasons for choosing to become nurse prescribers and their perceptions of their emerging role. More information is needed to inform the selection, education and support of nurse prescribers.

**Method.** All nurses who undertook a nurse prescribing course in one university in the West Midlands during 2003–2004 were invited to participate in the study. A 40-item questionnaire was used to gather data on demographics, expectations of nurse prescribing, personal and professional development and perceived education needs.

**Findings.** Respondents considered that, despite initial problems, the nurse prescribing initiative would ultimately prove to be a cornerstone of improved service delivery for service users. The majority of nurses were already heavily involved in prescribing ‘by proxy’ and the course merely formalized what they were currently doing. Potentially, prescribing could advance the professional development of nurses, improve communication between professionals and patients, and make the experience of patients more beneficial. However, some concerns were expressed about how supportive the current climate in health care could be, given the multiple demands on time and energy required by so many other innovations.

**Conclusions.** Respondents appeared balanced in their perceptions of this innovation and what it could realistically achieve. They were not indifferent to the many short and long-term problems that need to be resolved before it can be claimed to have become embedded in practice. The success of non-medical prescribing may depend on organizational support, coupled with a robust continuing professional development strategy for all nurse prescribers.

**Keywords:** clinical practice, education, nursing, prescribing, professional development

## Introduction

Nurse prescribing is a non-medical approach to prescribing which has become common in the United Kingdom (UK) in the last 2–3 years. The Department of Health (DoH) is responsible for supporting the UK government in their attempts to improve the health and well-being of the population, and in May 2001 they outlined plans to extend nurse prescribing. These included opening-up qualifying courses to a wider range of nurses and enabling qualified nurse prescribers to prescribe from a broader range of medicines for people with a wide range of conditions. In 2002, the UK government announced the intention to have a minimum of 1000 pharmacists and 10,000 nurses qualified as prescribers by the end of 2004 (DoH 2002a). The assumption underlying the call for greater numbers of nurse prescribers was that they would decrease the burden on doctors and reduce waiting times for service users. There are two forms of nurse prescribers in the UK: supplementary and independent. In theory, supplementary prescribers can prescribe from the entire British National Formulary, with the exception of Controlled Drugs (mainly narcotics and drugs of addiction) and unlicensed medicines, once a clinical management plan has been established by the whole care team. Independent nurse prescribers are restricted to items in the Extended Nurse Prescribers' Formulary (ENPF). In England, 1800 nurses are currently registered to prescribe from the ENPF and an estimated 1400 are registered as supplementary prescribers (Mullally 2004). Thus, the number is considerably less than the 10,000 that anticipated by the end of 2004 (DoH 2002a), but is steadily rising. Although the DoH is behind the drive for increased numbers of nurse prescribers in the UK, it falls to individual health organizations and academic institutions to collaborate and decide how best to implement nurse prescribing in practice. Little information is currently available on to the profile of these nurse prescribers and how they perceive their new roles.

McCann and Baker (2002) have provided limited profile data on independent nurse prescribers in the UK. They reported that they were aged between 30 and 49 years, with an average of 12.8 years of nursing experience. Despite the considerable amount investment in nurse education in recent years, the number of graduate nurses has remained relatively constant over the past 15 years at approximately 10%. This suggests that education is being targeted at front-line staff to ensure that they have the relevant practical skills rather than at the higher level skills of strategic planning and innovation (McCormack *et al.* 1999, DoH 2002b). Roles such as advanced clinical practitioner, specialist practice nurse, consultant nurse and nurse prescriber require a sound

educational background, extensive clinical skills and experience, the ability to exercise critical judgement and the vision to shape services so that they address need and maximize patient choice. During the early phases of the introduction of nurse prescribing, it will be interesting to identify what factors nurses themselves consider important to the role and why they have chosen to become nurse prescribers.

## Background

Prescribing is a highly skilled activity. Expenditure on drugs currently represents the largest proportion of UK National Health Service (NHS) costs after staff (Chapman 2004). If this money is to be spent efficiently, the challenge is to identify which skills are required for effective prescribing and to promote concordance with medication regimes. The 17.5 million adults with chronic diseases in the UK (Mullally 2004) are a particular prescribing concern as the majority of prescriptions are thought to be for such conditions (Humphries & Green 2002). Approximately half of all prescriptions are taken incorrectly (Audit Commission 2001). Even more problematic is the high rate of prescribing errors, which result in iatrogenic harm (Avery *et al.* 2002, Sandars & Esmail 2003, Taxis & Barber 2003). Fairman *et al.* (1998) suggest that there are considerable problems with the accuracy of diagnoses and the subsequent appropriateness of prescribing, while Isacson *et al.* (1996) describe the difficulties some prescribing clinicians have with forming relationships with recipients. Kass *et al.* (2000) argue that more information is needed about the characteristics of prescribers, how they relate to clients and patients, and the contexts in which they work.

As nurses have more contact with service users, as well as good communication skills, they have an important role in improving patients' experiences of health care and enhancing concordance (Pearce 2003). Studies in the USA suggest that nurse prescribing is now considered a means of improving the health care of people who previously had difficulty gaining access to services (Saur & Ford 1995). Not only were nurses found to be as competent as physicians in the management of treatments that used medication and in achieving patient outcomes, but they were considerably less costly (Baradell 1995). Patients reported that nurse prescribers brought two important aspects to their care: extra time to discuss treatment and higher quality of care (Mundinger *et al.* 2000). The ability of nurses to communicate effectively about medications is vital as patient beliefs about medication, and their understanding of their diagnosis, influence their adherence to treatment (Kemp *et al.* 1997). The close and continuing contact that a supplementary prescribing relationship

necessitates should place nurse prescribers in an ideal position to negotiate treatment schedules (Cumberlege 2003).

Although benefits of nurse prescribing, such as improved concordance and decreased waiting times, are frequently cited (DoH 2002b, 2004), nurses and other healthcare professionals are still voicing concerns about the initiative. Despite this, doctors working outside of hospitals (General Practitioners, GPs) have been found to be largely supportive (Wilhelmsson & Foldevi 2003). There are currently two schools of thought about the potential impact of nurse prescribing on the development of nursing; the first it as a backwards step, prioritizing 'cure' over 'care' (Cutcliffe & Campbell 2002) and the second as formalizing the 'informal' prescribing that many nurses already undertake (Nolan *et al.* 2001, Ramcharan *et al.* 2001). Humphries and Green (2002) cited the possible resistance that nurse prescribers may experience from other healthcare professionals. Nurse prescribing represents a major challenge to the traditional medical hierarchy, with the potential to cause conflict (Baird 2000). However, it is peer and professional support that helps nurses to keep their prescribing information up-to-date and encourages their confidence in the prescribing role (Fijn *et al.* 2002).

The NHS demands that nurse prescribers keep up with best practice and places a duty on all professionals to ensure that care is satisfactory, consistent and responsive (Parker 2000). Nurse prescribers will have to deal with ethical conflicts, such as pressure to prescribe from patients and the interest of drug companies, and must be committed to evidence-based practice (Dean *et al.* 2002, Humphries & Green 2002). In the first evaluation of district nurse and health visitor prescribing in the UK, Luker (1997) found that, similar to GPs, some nurses made prescribing decisions based principally on experiential knowledge of the patient. Although this kind of knowledge is important, nurses must be able to combine it with evidence-based practice and accurate assessments in order to select appropriate medication (Basford 2003). If there is resistance from healthcare colleagues, nurse prescribing may not fulfil its potential. Furthermore, nurse prescribing is unlikely to succeed without organizational support in the form of time for continuing professional development (CPD).

## The study

### Aim

The aim of the study was to elicit background data from recently qualified nurse prescribers and explore aspects of their work, including why they chose to become prescribers, explore what they saw as the advantages and disadvantages

of nurse prescribing, and how they expected to be perceived by colleagues.

### Design

A survey design was adopted, using a 40-item, self-report questionnaire containing both closed and open questions. The data were collected in 2003–2004 as part of extended research to evaluate the impact of nurse prescribing on healthcare delivery in the West Midlands, UK.

### Participants

The participants were four cohorts of nurses at one university who were attending a prescribing course that would, on successful completion, enable them to practise as supplementary and 'extended' nurse prescribers. This type of course will be referred to as a 'dual prescribing' course.

### Data collection

Four cohorts of nurses attending prescribing training were asked to complete the 40-item questionnaire during one of their training days at a university in the West Midlands, UK. The questionnaire was designed and piloted by the authors (EB & PN), and was divided into four sections:

- Demographic information and details of current role.
- Expectations of nurse prescribing.
- Personal and professional development.
- Education.

### Validity and reliability

The questionnaire was piloted with an earlier cohort of nurse prescribing students ( $n = 25$ ) and discussed at a support meeting for qualified nurse prescribers. The final version incorporated amendments made as a result.

### Ethical considerations

Approval to approach nurses within the university was gained from the local university ethics committee, and permission to approach nurses in their workplaces was gained from an Multi-Centre Research Ethics Committee. Nurses attending the prescribing course at the university were approached by the first author early in their course. An information sheet explaining the project was handed out and a question-and-answer session about the project was held by the lead researcher. Sessions were held at the end of the teaching day so that nurses with no interest in the study could

leave without participating. A consent form was given to all those interested in participating, and this was returned with the completed questionnaire.

### Data analysis

Data were entered analysed using the Statistical Package for the Social Sciences. Responses to the open-questions were subjected to content analysis to identify themes, and these were then ranked in order of importance.

## Findings

### Demographics

All 91 nurses in the cohorts agreed to participate in the study. The demographic and professional details can be seen in Tables 1 and 2.

Respondents were asked which prescribing role they were predominantly interested in adopting once they had qualified as prescribers. Seventeen (19%) identified that they would be prescribing independently, 41 (45%) that they would be prescribing solely in a supplementary capacity and 33 (36%) planned to do both.

### Current role

Respondents were asked to state their current contribution to prescribing decisions (Table 3). Seventy-eight nurses (86%)

**Table 1** Demographic details

Gender	Male: 21 (33%); Female: 70 (77%)
Age	Mean: 41 years; Range: 28–59 years
Years qualified	Mean: 18 years; Range: 4–37
Qualifications held	Degree: 28 (31%); Postgraduate degree: 13 (14%)

**Table 2** Professional details

Grades* ( <i>n</i> = 86)	
E	3 (4%)
F	14 (16%)
G	44 (51%)
H	25 (29%)
Workplace ( <i>n</i> = 88)	
Hospital	36 (40%)
Community	29 (32%)
General practice	20 (22%)
Across all 3	3 (3%)
Other	3 (3%)

\*Grades denote seniority with E being a junior nurse and G being a senior nurse.

felt that they already had an important role in giving advice about prescribing to medical colleagues. Thirty-seven (41%) thought that they acted as advocates for patients, with a particular focus on giving advice about medication choices. Twenty nurses (22%) felt that they were already prescribing ‘by proxy’ in their current roles.

Respondents were asked to describe the two skills they felt were most important to their current role (Table 4). The most important skills used currently were interpersonal skills (*n* = 79; 87%), including communication, negotiation and advocacy. Important clinical skills included the provision of specialist knowledge (*n* = 39; 43%) and assessment skills (*n* = 28; 31%). Only one nurse felt that they used medication management skills in their current role.

### Why nurse prescribing?

Respondents were asked why they had undertaken a nurse prescribing course (Table 5). Two indicated that they had been directed to take the course in order to fulfil the requirements for a new job rather than having chosen it themselves because they were interested in nurse prescribing. Ninety believed that prescribing would advance their practice and 80 felt that it would increase their ability to work autonomously. Ten nurses disagreed that prescribing would increase their autonomy, and were asked to qualify this response; six thought that supplementary prescribing was a team rather than autonomous activity and three that prescribing was already part of their practice and that the qualification would merely legitimize this. Another four replied that restrictions in the ENPF and current setting of nursing practice prevented any potential increase in autonomy.

Respondents were asked whether they thought that nurse prescribing would improve patient care (Table 6). Eighty-nine (98%) said that it would, and the reasons given for this included saving patient time (*n* = 37; 42%) and providing a complete package of care (*n* = 34; 38%). It was hoped that prescribing would further promote user-led care (*n* = 27; 30%) in the form of advocacy and encouraging good communication about medication choices between nurse prescribers and their patients.

### Expectations of the nurse prescribing role

In a question about their future prescribing role, respondents were asked to outline which two skills they felt would be most important (Table 7). Forty-three nurses (48%) thought that communication skills would be vital for their future prescribing roles. Important specialist skills included those of

**Table 3** Current contribution to prescribing decision-making ( $n = 90$ )

Rank	Contribution	No. of nurses	%
1	Provide advice to medical colleagues (e.g. general practitioner, junior hospital doctor)	78	86
2	Act as patient advocate: advising patients, eliciting patient preferences, and providing education with respect to prescribed medication	37	41
3	'Informal' prescribing (including 'emergency' interventions, reviewing patient data for assessment, diagnostic, treatment and prescribing decisions)	20	22
4	Medication management (monitoring concordance and side effects and preventing relapse)	13	14
5	Running nurse-led clinics and initiatives (including triage, health promotion)	13	14
6	Working as an independent nurse prescriber and using Patient Group Directives	4	4

**Table 4** Two most important skills used in current role\* ( $n = 91$ )

Rank	Most important skills	No. of nurses	%
1	Interpersonal skills (communication, negotiation and advocacy)	79	87
2	Providing specialist knowledge (including evidence based practice and education)	39	43
3	Undertaking assessments and decision-making	28	31
4	Organizational skills (including time management and exercising leadership)	22	24
5	Team work	4	4
6	Care co-ordination	3	3
7	Risk management	1	1
7	Medication management	1	1

\*Whilst piloting the questionnaire the respondents were asked to outline those skills they felt were most important to their current role. Analysis of the pilot questionnaires demonstrated that the respondents tended to make long, sometimes repetitive, lists of skills so it was decided to limit the respondents to outlining their two most important skills.

**Table 5** Reasons for undertaking nurse prescribing course ( $n = 91$ )

Rank	Reasons for undertaking course	No. of nurses	%
1	To provide a complete package of care (delivering nurse-led specialist services, chronic disease management and health promotion)	43	47
2	Professional development (skills and knowledge enhancement)	33	36
3	To improve patient care by providing more appropriate and sensitive care, and develop client centred services	22	24
4	To save time (for patient, nurse and doctor)	11	12
4	To formalize current prescribing activities	11	12
5	To increase autonomous working	10	11
6	Medication management	1	1

assessment and diagnosis ( $n = 34$ ; 38%), pharmacological knowledge ( $n = 30$ ; 34%) and prescribing knowledge ( $n = 27$ ; 30%).

Respondents were asked to think about whether their colleagues would perceive them differently once became nurse prescribers. Sixty (66%) felt that they would be perceived differently and their comments are reported in Table 8. Eighteen nurses (30%) felt they would be treated as a resource by their team members and hoped that this would alleviate the workload for teams, as well as increasing patient

access to services. There were, however, concerns that colleagues might misunderstand the new role ( $n = 14$ ; 23%) and that this could encourage abuse of it.

Twenty-nine (32%) respondents did not think that there would be any change in their colleagues' perceptions of them once they were qualified as prescribers. In five cases (17%), this was because they were already working autonomously. Five nurses (17%) reported that all their colleagues would also be completing the course, and so there would not be any change in how they were perceived

**Table 6** How will nurse prescribing improve patient care? ( $n = 89$ )

Rank	Ways in which nurse prescribing will improve patient care	No. of nurses	%
1	By saving patient time (quicker access to care, nurses using time with patients more efficiently – not waiting around for a GP signature)	37	42
2	By providing a complete, holistic* package of care	34	38
3	By enabling user-led care (including patient advocacy, better communication and more quality time with patients)	27	30
4	By providing more responsive patient care (quicker access to treatment and specialist knowledge)	24	27
5	Through better medication management	9	10
6	By increasing patient safety	2	2

GP, general practitioner.

\*It is not possible to unpack the meaning of 'holistic' care – which may include medication management for some nurses – as the participants were not asked to define what they meant by holism.

**Table 7** Two skills that nurses consider important for future prescribing role ( $n = 89$ )

Rank	Skills	No. of nurses	%
1	Communication (including listening and information giving) to enable user-led care	43	48
2	Consultation, assessment and diagnosis	34	38
3	Specialist pharmacological knowledge, clinical skills	30	34
4	Making effective prescribing decisions and providing evidence-based care (including initiating and adjusting therapy)	27	30
5	Knowledge of their responsibilities, accountability and the legal issues for nurse prescribing	15	17
6	Education	10	11
7	Working with the Clinical Management Plan	4	4
8	Medication management	3	3
9	Time management	2	2

**Table 8** How will nurse prescribers be seen by colleagues? ( $n = 60$ )

Rank	Comments	No. of nurses	%
1	As a resource for the team, alleviating workload and enhancing access for patients	18	30
2	Colleagues may misunderstand the new role, thinking nurses can prescribe anything (with potential for abuse of the role)	14	23
3	As more autonomous practitioners	11	18
4	As challenging 'traditional' roles – and maybe as 'mini doctors'	6	10
5	Expectations of their role would be higher	5	8
6	They would be expected to demonstrate evidence of enhanced practice and provide complete care packages	4	7
7	As more knowledgeable	1	2
7	They may cause some disruption to working relationships	1	2

as they would all have the same qualification. In two cases (2%), nurses thought that the addition of a prescribing qualification would have no impact on colleagues' attitudes because they already commanded respect as specialist nurses.

When asked whether they thought that they would be perceived differently by their *patients* once they were qualified as nurse prescribers, 51 (56%) respondents felt that patients would notice a change (Table 9). However, 36

(40%) did not consider that patients would notice any changes. Eight (9%) noted that they were already communicating with patients about prescribing decisions, and their prescribing qualification would only formalize this. A further eight (9%) commented that the setting they worked in meant that most of their patients were new to services and so the point was not relevant, and four (4%) noted that patients would not mind who wrote their prescriptions as long as they received the medication they needed.

**Table 9** How will nurse prescribers be viewed by patients? ( $n = 51$ )

Rank	Comments	No. of nurses	%
1	As providing easier access to medication and advice	28	55
2	Patients will have higher expectations of nurses' ability	9	18
3	Patients won't understand what nurses can/can't prescribe	8	16
3	Some may have difficulty accepting changed role and be confused by blurring of roles between nurses and medics	8	16
4	Patients will notice they adhere better to their medication regimes	1	1

**Table 10** What concerns do you have about nurse prescribing? ( $n = 76$ )

Rank	Concerns expressed by potential nurse prescribers	No. of nurses	%
1	Implementation in specific settings; the CMP; IT systems	29	38
2	Increased responsibility and accountability	19	25
3	Misconceptions about the role (including increased pressure to prescribe)	17	22
4	Support after qualification and opportunities for CPD	16	21
5	Increased workload and insufficient time	13	17
6	Moving from 'caring' to 'curing'	8	10
6	The limitations of the formulary and the CMP	8	10
7	Lack of remuneration	2	3
7	Unknown political motives behind nurse prescribing	2	3

CPD, continuous professional development; IT, information technology; CMP, clinical management plan.

### Concerns about nurse prescribing

Respondents were asked to outline any concerns they had about nurse prescribing and the concerns of seventy-six (83%) are summarized in Table 10. A prominent concern was how to implement the new prescribing role in practice ( $n = 29$ ; 38%). There were also concerns about the increased accountability and responsibility ( $n = 19$ ; 25%), as well as fear that colleagues might abuse the role through misunderstanding it ( $n = 17$ ; 22%). Another important concern was the availability of support for nurses once they had qualified as prescribers, particularly with regard to opportunities for CPD ( $n = 16$ ; 21%).

### Discussion

In this study we examined which nurses have elected to become prescribers, why they have chosen to do so, and their expectations of their future role. The sample was slightly older than a sample of independent nurse prescribers surveyed in 2002, and had a broader age range and more experience (McCann & Baker). It is interesting to note that the gender divide for more advanced nursing roles does not show a swing away from female to male dominance as it has with certain management roles in the past. The sample included a notably high proportion of nurses with a degree (31%) and those qualified at postgraduate level (14%) compared with 10% of the total UK nursing workforce with

a degree-level qualification. This suggests that the early cohorts taking the dual nurse prescribing qualification were 'high flyers', either self-selected or selected by employers on the basis of their academic qualifications and experience to carry the initiative forward. In future, employers will need guidance on which nurses to select for the course as increasing numbers apply to attend. Further research should focus on the skills and qualities which lead to successful implementation of the nurse prescribing role.

In the current sample there were almost as many nurse prescribers working in hospitals as in the community or in GP practices. Respondents working in hospital settings had the most concerns about implementing their new role. Supplementary prescribing is a highly collaborative activity that requires ongoing patient contact and communication to monitor its effects. As Green (2004) suggests, the hospital environment may make this type of collaboration difficult. It will be important to evaluate the experiences of the early cohorts of supplementary prescribers as they implement their new roles.

The majority of nurses in our sample thought that they would use their supplementary prescribing role either exclusively, or occasionally, after qualification. The dual qualification for nurse prescribing currently consists of 26 days of study; however, much of the course focuses on the independent prescribing role and only two days concentrate on supplementary prescribing. With such a high proportion of the sample intending to act as supplementary prescribers, it

may be worth considering whether these 2 days are sufficient to deal with its implications. As more nurses working with patients with a variety of chronic diagnoses choose to become prescribers, it might be helpful to take a look at the courses offered and consider whether such a broad course is appropriate. Dual qualification courses have evolved considerably since their introduction in early 2003, and it is likely that they will continue to develop. It is important that nurses who have already qualified from these courses are given the opportunity to feed back their experiences of implementing their new roles to course leaders so that these experiences can inform course development.

Increased workload worried the nurses in this sample, although nearly a fifth thought that they already had good organization and time-management skills. Respondents were generally holding senior positions and were likely to have received education in time management. The increased workload may be even more challenging for the less experienced nurses who will soon be participating in the prescribing initiative. While they are implementing nurse prescribing, they will need to negotiate their new roles within current systems. Skills of time management, prioritizing workload and negotiation will be the keys to success and should be considered for inclusion in prescribing courses.

Six respondents had been sent on the prescribing course rather than volunteering for it. For them, successful completion of the course was a job requirement. Now that the prescribing qualification has been extended to all nurses, prescribing will be incorporated into many more nursing roles and will become a prerequisite for certain posts. Whether nurses will resist pressure to become prescribers remains to be seen. With the early prescribing courses, district nurses and health visitors were 'strongly encouraged' to become prescribers and given very little opportunity to opt out. The numbers of these nurses who went on to assume a prescribing role has been well below what was originally anticipated (McCann & Baker, 2001).

Respondents' reasons for completing the nurse prescribing course were in line with those quoted in literature from the United States of America, including the opportunity to give nurse-led, holistic care, improved and responsive patient care, and the time saved for both nurses and patients. Whether these anticipated benefits are realised in practice remains to be seen. Respondents felt that they were already making a substantial contribution to prescribing decisions through 'informal' activities such as offering expert advice, patient advocacy and undertaking assessments. Qualifying as prescribers would, therefore, enable them to formalize these activities. The majority thought

that prescribing would increase their ability to work autonomously, particularly within nurse-led services. There are important implications here for the UK as general medical practices have an increasing amount of flexibility in designing their services and may be keen to offer nurse-led care (Royal College of General Practitioners 2003). Importantly, professional development was another powerful motivator for enrolling on the nurse prescribing course. Prescribing may represent a way of advancing the nursing role and increasing morale within the workforce. Continuing professional development is vital to support the prescribing role, and organizations must make time available for nurses to update their knowledge. Future research is required to examine the nature and extent of CPD required for this purpose.

The nurses in this study could see a number of benefits to adopting a prescribing role. They did not appear to be concerned about the role replacing other 'caring' skills traditionally associated with the nursing role and were comfortable with the shift to becoming competent practitioners who could also prescribe. Although the literature suggests that nurses are well-placed to monitor the impact of prescribed medication on their patients, only 13 respondents (14%) said that they currently had a role to play in medication management and monitoring side effects and early signs of relapse. It will be interesting to see whether nurses increase their input to medication management once they qualify as prescribers, and include this within their care. If medication management does not become an integral part of the prescribing role, there is the danger that prescribing will be viewed as an isolated technical skill.

It is interesting that, although nearly all respondents thought that gaining the prescribing qualification would enable them to improve patient care, 40% did not consider that patients would notice any change in their role. Where nurses were working in hospital settings, this was because they felt that they did not form relationships in which patients would notice their role change. In the community, nurses did not anticipate making any major changes to their daily activities once they qualified as prescribers, so it is unlikely that a patient would notice any change. This draws attention to the prescribing 'by proxy', whereby nurses write prescriptions for GPs to sign. There are currently few systems in place to support supplementary prescribing, and nurses will need to negotiate their new role within current systems. Our findings suggest that they may have under-estimated the potential difficulties associated with adopting their new prescribing roles. This could be problematic, as early difficulties integrating the new role

### What is already known about this topic

- Nurse prescribers have an important role to play in enhancing concordance with treatment regimes as they have good communication skills and greater contact with service users when compared with medical prescribers.
- Prescribing is a highly skilled activity, and more information is needed about factors that could encourage its effectiveness.
- There is limited information about the characteristics of nurses choosing to extend their roles in this way.

### What this paper adds

- As increasing numbers of nurses apply to become prescribers, employers will need guidance on whom to select for qualifying courses.
- Although nurses appear enthusiastic about their future prescribing roles, there needs to be an organizational commitment to support nurse prescribing.
- Potential nurse prescribers come from a variety of backgrounds and have varied educational and support needs and educational courses need to ensure that these needs are met.

could discourage nurses from employing their prescribing ability.

### Study limitations

Although this study was probably one of the largest conducted so far on supplementary and extended nurse prescribers in England, it has some limitations. In particular, the majority of nurse prescribers accessed were employed by one local organization. This organization has been particularly supportive of the nurse prescribing initiative and so the experiences of these nurses may not reflect those of nurses working in less supportive healthcare organizations. Although the questionnaire contained a number of open questions, some respondents needed more time to complete them. Furthermore, nurses were asked to anticipate the reactions of their colleagues to their future prescribing roles before they have actually qualified as prescribers. Our future work will tackle some of the limitations of this early study by extending the work to nurse prescribers throughout the West Midlands and inviting nurse prescribers to participate in an interview study to discuss their thoughts and experiences of prescribing in more detail.

### Conclusions

It appears that employers initially put forward 'high flying' nurses to undertake nurse prescribing courses, probably to help ensure the success of the initiative. As nurse prescribing is rolled out and demand for places increases, employers will need to determine which skills are associated with successful nurse prescribing in order to select candidates appropriately. Nurses need to know what are the necessary skills and qualities so that they fully understand the demands of this work.

Our respondents believed that nurse prescribing can play an important part in realizing user-focussed care. However, the impact of nurse prescribing on colleagues and on traditional healthcare provision was thought to be problematic. It is essential that misconceptions about the nurse prescribing role are addressed. Systems to support non-medical prescribing are vital, particularly organizational support and a clear strategy for CPD. There must be a commitment to ensuring that nurse prescribing adds to nurses' therapeutic skills rather than replacing them, thereby facilitating a more responsive and effective service for patients.

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### Author contributions

EB and PN undertook the study conception and design. EB and PC collected the data. EB, PC and PN performed the data analysis, drafting of the manuscript and performed critical revisions. EB provided statistical expertise and administrative support. PN obtained funding.

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