Independent Non-medical prescribing in the ED is it safe?

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Objectives

• What’s an Advanced Clinical Practitioner (ACP) at HEFT

• Reprise on Non-Medical Prescribing

• ACP Prescribing in the ED at HEFT

• Is it safe? Our Audit

• The governance framework supporting ACP prescribing - reflective supervision, our tool
What’s an ACP?
ACP’s at HEFT…

• Practise autonomously as an advanced practitioner within emergency care to provide patient-centred clinical care.

• Utilise the skills of assessment, examination, diagnosis and treatment within an agreed scope of practice throughout the Emergency Department (ED).

• Support a new way of working that emphasises a more efficient and patient focused service, and will ensure the safe referral and discharge of patients with undifferentiated and undiagnosed presentations in any area of the ED.

• Deliver 80% clinical component to their role and 20% related to appraisal, clinical audit, teaching, self development and research.
Advanced Practice at HEFT

ODP’s in Resus
Nurse Consultant
Adult ACP (ECP)

ENP

Adult ACP

Paeds ACP
The art of medicine consists of amusing the patient while nature cures the disease.

Voltaire 1694 - 1778
Prescribing Timeline

• 1994 – DN/HV formulary nurse prescribing
• 2002 – Extended formulary nurse prescribing
• 2003 – Supplementary nurse prescribing allowed to include chiropodists/podiatrists, physiotherapists and radiographers to join non-medical prescribing group.
• 2006 – Nurse independent / supplementary Rx
Different Prescribing Components

• Patient Group Directions

• Supplementary Prescribing

• Independent Prescribing
Patient Group Directions (PGD)

A written instruction for the supply or administration of a licensed medicine(s) in an identified clinical situation, where the patient may not be individually identified before presenting for treatment.

PGD’s are drawn up by doctors, pharmacists and other health professionals and must meet certain legal criteria. Must be signed by a doctor / dentist, pharmacist and approved by the organisation.

Supplementary Prescribing

Introduced April 2003 – Nurses and Pharmacists

May 2005 – Extended to physiotherapists / chiropodists/podiatrists/ radiographers and optometrists

Supplementary prescribing is a voluntary prescribing partnership between the independent prescriber (doctor or dentist) and supplementary prescriber, to implement an agreed patient-specific clinical management plan (CMP), with the patient’s agreement.

Independent Nurse Prescribing

May 2006

Independent nurse prescriber’s in UK have ability to prescribe any licensed medicine for any medical condition within their scope of competence

• DH Guidance is 3 yrs post-registration experience
• Should possess skills in clinical examination (take history, examine and diagnose)
• Standalone Course – 26 days theory
• 12 days mentored practice
• Pass examination criteria – NMC and University
• Must register qualification with NMC

Except......Drug Limitations

There is specific palliative guidance but in an ED setting the following guidance applies:

- Diamorphine/Morphine for pain relief in respect of suspected M.I./relief of acute or severe pain after trauma including in either case post-op analgesia

- Diazepam, Lorazepam or Midazolam for tonic-clonic seizures

- Diazepam or Chlordiazepoxide for treatment of initial or acute withdrawal symptoms, secondary to the withdrawal of alcohol from persons habituated to it
WebLinks

• British National Formulary (BNF) www.bnf.org/bnf

• Examples of Patient Group Directions (PGDs) www.portal.nelm.nhs.uk

• Medicines Partnership Programme www.medicines-partnership.org

• National Electronic Library for Health www.nelh.nhs.uk

• NHS Drug Tariff for England & Wales www.ppa.org.uk/ppa/edt_intro.htm

• NHS National Practitioner Programme www.wise.nhs.uk

• National Prescribing Centre www.npc.co.uk

• Nursing and Midwifery Council www.nmc-uk.org

• Prescribing news www.nurse-prescriber.co.uk

• Royal Pharmaceutical Society of Great Britain www.rpsgb.org
Medication Error

• 40,000 medication errors are made in the NHS in a year

• 2,000 cause moderate to severe harm
  NPSA 2006

• 6.5% of admissions to an acute MAU drug related

• 35% were prescription errors
  Howard 2003

• (2%) of total errors were in the emergency department;
Drug Errors in Hospital

Numbers differ depending on reporting voluntary self-reporting of errors at 0.15 per cent (Ross et al., 2000)

Observational methods have estimated error incidence at 19 per cent (Barker et al., 2002)

retrospective medical record review of ADE at 2 per-cent (Wilson et al., 1995),
Our Study compared drug errors

3 RN independent prescribers

3 Medics
1 SpR and 2 SHO’s
Results

3 Medics
1 SpR and 2 SHO’s

21% (20/95)

3 RN independent prescribers

10% (4/40)
Belt “n” brace

10 nurse prescriptions were explored by case review and prescribing rationale with an ED Consultant

highlighted sound clinical reasoning and documentation
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Example of Case Review: 18-month old male

Professional Identification

History suggests urinary symptoms

Initial urinalysis negative

Consider issue of consent by ascertaining parental responsibility

Examination comprehensive Chest, limited Abdominal, ENT missing

Appropriate diagnosis reached

Prescribed medication for 5-days, NICE guidance recommends 3-days only, MC&S result and follow-up by GP at 3-days (letter)

Blanked to protect anonymity of child
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A-Z Personal Prescribing Practice Formulary

The formulary is an alphabetical arrangement of the drugs more commonly used within my specific clinical practice.

It is not meant to replace the BNF but supplement learning and understanding with specific regard to the pharmacodynamics and pharmacokinetics of the drugs commonly prescribed.
Recommendations?
None of this!!!
Recommendations

• Larger scale audit of prescribing practice, integrated into the Directorate clinical governance strategy

• To develop independence from medical clinical supervision, by introducing peer support and future supervision of junior colleagues
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Questions are guaranteed in life; Answers aren't.

Over to you