GOULD, J. and BAIN, H. 2022. Professional, legal and ethical dimensions of prescribing: part 1: professional. *Primary health care* [online], 32(6), pages 20-26. Available from: https://doi.org/10.7748/phc.2022.e1773

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2022

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Professional, legal and ethical dimensions of prescribing. Part 1: professional

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Abstract

Prescribing by nurses and midwives continues to expand and has consistently been evaluated as safe and effective. This article is part one of two exploring the core professional, legal and ethical dimensions of prescribing. Reference is made to a contemporary prescribing model, RAPID-CASE, devised by the authors to demonstrate the application of key prescribing practice principles. The importance of a structured approach is demonstrated with reference to the Royal Pharmaceutical Society competency framework for all prescribers, applicable legislation and underpinning ethical principles. This first article identifies the main professional dimensions of prescribing practice, while the second article focuses on the legal and ethical aspects.

Keywords

Clinical, Community, District nurses, General practice, Medicines, Nurse prescribing, Prescribing, Prescription medicines, Primary care

Prescribing by nurses and midwives continues to expand with more than 90,000 prescribers on the Nursing and Midwifery Council (NMC) register as of 31 March 2021 (NMC 2021) (Table 1). Nurse and midwife prescribing has repeatedly been evaluated as safe and effective, with a broad range of positive outcomes associated with its development (Latter et al 2005, 2010, 2011, Smith et al 2014, i5 Health 2015). A more recent study found that community nurses regarded prescribing as an essential part of their role (Courtenay et al 2018). It is expected that after registration with the NMC, nurses and midwives will already be equipped to progress to the completion of a prescribing qualification (NMC 2018a, 2019).

Table 1. Number and qualification of nurse prescribers on the Nursing and Midwifery Council (NMC) register, 31 March 2017 to 31 March 2021

MNC course code	Qualification	31 March 2017	31 March 2018	31 March 2019	31 March 2020	31 March 2020
V100/V150	Community practitioner nurse prescriber	40,612	40,748	40,879	41,049	41,301
V200	Nurse independent prescriber	1,449	1,375	1,292	1,211	1,152
V300	Nurse independent and supplementary prescriber	36,983	40,041	43,717	47,899	50,693
Total		79,044	82,164	85,888	90,159	93,146

(NMC 2021)

Data showed that during the coronavirus disease 2019 (COVID-19) pandemic, fewer GP consultations took place in England with a corresponding 30% drop in the rate of new prescriptions per individual

(Watt et al 2020). With guidance for GPs to prioritise home visits, there was a notably greater reliance on district and community nurses (Bowers et al 2020, Green et al 2020). The combined pressures on primary and secondary care (Oliver 2020) intensified the need for prescribing by community practitioners (V100/V150), or independent (V200) and supplementary (V300) prescribers (NMC 2018b). Table 2 shows the various types of nurse and midwife prescribers and their formulary responsibilities.

NMC course code	Title description	Formulary
V100	Community practitioner nurse prescriber Integral to the Specialist Practitioner Qualification (for example, district nursing and general practice nursing) education programme and optional in a Specialist Community Public Health Nursing course	Can prescribe independently from the NPF for Community Practitioners
V150	Community practitioner nurse or midwife prescriber Can prescribe from the Nurse Prescribers' Formulary (NPF) for Community Practitioners (National Institute for Health and Care Excellence and Nurse Prescribers' Advisory Group 2022) as a stand-alone course, not linked to a specialist or other post-registration nursing programme	
V200	Nurse or midwife independent prescriber Programmes no longer offered but there are still some NMC registrants with this qualification. Were only able to prescribe from an 'extended formulary' before legislative changes in 2003 to add supplementary prescribing. V200 prescribers can now prescribe as independent prescribers on the same basis as V300 prescribers but not as supplementary prescribers	Can prescribe independently from the British National Formulary (BNF) with some controlled drug exceptions
V300	Nurse or midwife independent and supplementary prescriber Qualification for prescribing courses for nurses or midwives to prescribe any medicine for any condition within their competence with some controlled drug exceptions. This title includes supplementary prescribing, that is partnership working with a doctor or dentist to implement a clinical management plan in agreement with the individual being prescribed for, and its holder can prescribe within a clinical management plan	Can prescribe independently from the BNF with some controlled drug exceptions and from the full BNF as a supplementary prescriber

(NMC 2018b, Gould and Bain 2022)

Research into the effect of COVID-19 on nurses and midwives identified the emotional strain involved, with nearly one third showing signs of post-traumatic stress disorder (Couper et al 2022). This study identified personal and workplace-related factors, such as organisations' responses to the pandemic in terms of availability of personal protective equipment and training, but it did not explore specific practice stressors (Couper et al 2022). Practical challenges for prescribers during the pandemic included remote consultations, working outside their usual practice area (Royal College of Nursing 2020), and staff shortages with fewer sources of clinical support. Increased risk such as that caused by COVID-19 makes it more vital than ever for nurses to be critically reflective and examine their prescribing in relation to various factors that might influence their decision-making.

This article reviews professional dimensions of prescribing practice with reference to a contemporary prescribing model, RAPID-CASE, devised by the authors (Gould and Bain 2022).

Professional dimensions of prescribing

The Nursing and Midwifery Order 2001 (www.legislation.gov.uk/uksi/2002/253/contents/made) established the NMC as a professional regulator with the legal authority to admit nurses and midwives to the register, annotate additional qualifications, suspend or remove registrants and set the educational standards for qualifications such as prescribing. Nurse and midwife registrants should be familiar with the expectations of their regulatory body, the importance of adhering to the Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates (NMC 2018c), and working within their professional scope of practice. However, prescribing is not within the scope of practice of everyone on the NMC register. Nursing associates cannot prescribe, but they may supply, dispense and administer medicines. It is only nurses and midwives who have successfully completed a

further qualification in prescribing and recorded it on the NMC register who can prescribe (NMC 2018b).

There can be ambiguity between staying within one's scope of practice and extending practice to meet fast-changing crisis situations or exceptional demand such as during the COVID-19 pandemic. For nurses, recognising themselves as accountable practitioners and fulfilling their duty of care are fundamental to practising professionally, and are guided by the Code (NMC 2018c). Accountability for clinical practice includes recognising the importance of continually improving clinical competence, ideally by measuring it against recognised frameworks, such as the Royal Pharmaceutical Society's (RPS) competency framework for all prescribers (RPS 2021).

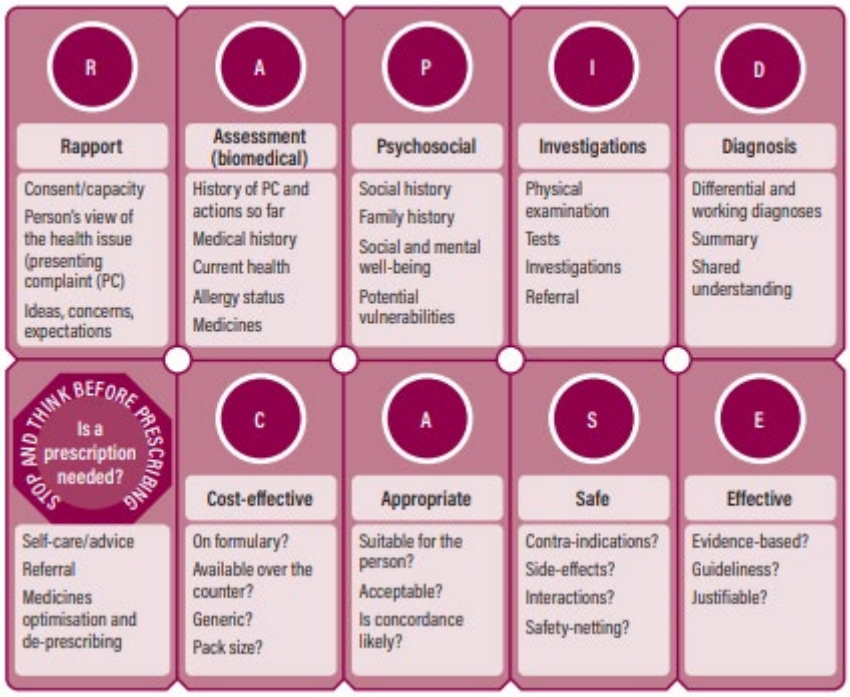
To fulfil the nurse's duty of care, their clinical practice should be framed by the four themes of the NMC (2018c) Code, that is prioritise people, practise effectively, preserve safety and promote professionalism and trust, with prescribing specifically linked to 'preserve safety'. Also specific to prescribing are the NMC (2018b) standards for prescribing programmes, which meet the RPS competency framework (RPS 2021), providing detailed expectations about consultation and governance.

Every clinical encounter requires a clinical decision, ranging from providing self-care advice or onward referral, to initiating a treatment plan including a prescription. Safe decisions are reliant on an accurate and thorough assessment, with some requiring physical examination. During the COVID-19 pandemic, there was an increased pressure to undertake consultations remotely. However, it is important to identify the importance of the 'senses', particularly touch, in any consultation and how they are often used to inform an assessment. For example, when undertaking wound care in people with darker skin tones, full use of the senses may be particularly important because there is less of a visual evidence base to inform assessment and diagnosis (Dhoonmoon et al 2021). Remote consultation is notably challenging in some areas of practice such as substance misuse (McAuley 2021), intellectual disability services (Rauf et al 2021), and wound care (Karadag and Sengul 2021). Adhering to additional guidance for remote consultations and prescribing ensures that the safety of the person receiving care is the primary concern (General Medical Council 2022). Common to all types of consultation is the need for attention to the person's unique circumstances. Considering the individual and their preferences, along with factors such as available resources, evidence, formularies, expert advice and adherence to or justified deviation from guidelines, supports safe and effective prescribing (Gould and Bain 2022).

A structured approach and reflecting on decision-making in the context of the RPS (2021) competency framework can support effective consultations. The purpose is to check practice against recognised standards, while prompting questions around making accurate differential diagnoses or fully attending to the individual's perspective when there are time constraints or competing demands. As per the competency framework (RPS 2021), a systematic approach should be used in taking an appropriate biopsychosocial history leading to a diagnosis and treatment plan. Denness (2013) suggested that using a consultation model supports the gathering and processing of information to guide decision-making, while the National Institute for Health and Care Excellence (NICE) (2019) identified that decision-making should be person-centred.

Suboptimal assessment can be linked to delays in care, misdiagnosis, error, harm, the lack of a baseline against which to judge improvement or deterioration, or a lack of concordance with treatment regimens (Munroe et al 2013, Gough 2018). A new model designed to guide decision-making in prescribing uses the mnemonic RAPID-CASE (Figure 1) (Gould and Bain 2022). RAPID-CASE integrates features from some recognised consultation models, considers the competency framework (RPS 2021) and combines elements from the 'prescribing pyramid' (also known as the seven principles of good prescribing), an early model for nurse prescribers published by the National Prescribing Centre (1999).

Figure I. RAPID-CASE model



Consultation: RAPID-CASE model

The RPS (2021) identifies the need to access and interpret all available and relevant healthcare records when assessing a person. While accessing records is not always possible, for a more efficient consultation records should ideally be checked before applying the RAPID-CASE model (Figure 1) (Gould and Bain 2022).

Rapport

Taking a stepped approach to the consultation using the RAPID-CASE model starts with developing rapport, which includes the nurse introducing themselves and explaining their role, and establishing the person's identity before moving on to the person's perspective of their health concern. The first stage also involves gaining consent for the consultation, which should be obtained alongside an assessment of mental capacity, since these must be contemporaneous (Department for Constitutional Affairs 2007, NMC 2018c).

Developing rapport is supported by initially exploring the person's ideas, concerns and expectations (Neighbour 1987). The use of open questions can prompt an understanding of the person's perspective and priorities (RPS 2021). It is important for the nurse to establish the main outcome or expectation, since this may be personal to the individual or change over time. For example, with wound care a prescriber may logically assume that the person wants the wound to heal, reflecting research suggesting that most people regard healing as the primary treatment goal (Cullum et al 2016). However, concerns about the inconvenience or discomfort of the treatments may emerge, to the point that the person's primary aim becomes comfort rather than healing. A leg ulcer or wound care assessment template can be useful for structuring the specific assessment, prompting prescribers to ask about pain and record findings. However, Gough (2018) argued that tools can be applied in an overly prescriptive way and potentially limit a partnership approach.

Assessment (biomedical)

While establishing rapport is the starting point in a RAPID-CASE consultation, an assessment of a person's biomedical status begins with initial observations such as appearance, demeanour, mobility or, in the case of remote consultations, more subtle indicators such as challenges with speech, hearing or understanding questions. The nurse's professional and legal duty of care necessitates that a full assessment be undertaken before any prescribing decision is made, although the initial observations could indicate that an urgent referral is the most suitable action (RPS 2021).

Prompts for a full biomedical assessment are often integral to assessment templates, but it is the responsibility of prescribers to identify when additional tools may be needed. For example, best practice guidelines for skin tear injuries suggest a Doppler assessment and compression therapy (Fletcher et al 2020), but this may not be included in an organisation's protocol or wound care assessment template.

Psychosocial

Essential parts of biomedical assessment, such as history of the presenting complaint, medical and medicines history are crucial, but it is important for the nurse to widen the assessment to include psychosocial considerations (RPS 2021, Gould and Bain 2022). For example, a qualitative study of consultations for people with leg ulcers found that most practitioners neglected to raise the topic of pain or the emotional effects, with very few addressing those issues or the effect on a person's daily life (Green et al 2018). While Green et al (2018) noted limitations in their study such as a small sample size, they emphasised that even highly skilled, experienced nurses may not proactively prompt discussions around the less 'clinical' aspects of care or address these wider issues in divergence from the NMC (2018c) Code or the competency framework (RPS 2021).

Social factors such as the person's degree of independence and availability of family support are also important to establish for effective planning and safety-netting, which is a way to communicate to the person information on urgent symptoms, persistent or new issues, and to plan for reassessment (Neighbour 1987, Jones et al 2019). Potential vulnerabilities are defined in the competency framework (RPS 2021) as possible signs of abuse, neglect or exploitation. The competency framework reminds prescribers to consider physical and mental health, particularly if treatment has been sought due to vulnerabilities or safeguarding concerns (RPS 2021).

Investigations

The nurse's clinical judgement should also be used to identify which, if any, physical examinations, tests or investigations are indicated. Knowledge of the condition, its trajectory and associated clinical findings are integral to this process. It is important to note that tests can be flawed or inaccurate, such as oxygen saturation readings being affected by suboptimal circulation, skin pigmentation, decreased perfusion, lack of calibration or inaccurate placement (Hafen 2021). For example, a safety alert was issued owing to oximeter probes being placed inappropriately, with findings that 'a substantial proportion of staff do not know that finger probes can give misleading results if attached to ears' (NHS Improvement 2018).

Hafen (2021) identified that treating an inaccurate oximeter reading as accurate is a significant risk because it may result in inappropriate treatment, leading to harm. Some diagnostic tests, such as Doppler assessment for possible venous leg ulcers, can be inconclusive and should not be considered definitive (Fletcher et al 2019), but instead taken in tandem with a thorough history. Clinical guidelines include diagnostic criteria and suggested investigations. The most recent guidelines should be used for

investigations and diagnosis, as well as for informing evidence-based prescribing treatment decisions (RPS 2021).

Diagnosis

Guidelines and frameworks can include diagnostic criteria and when used in tandem with a structured consultation and investigations, a working diagnosis can be made. The competency framework (RPS 2021) outlines that prescribers need to be able to make, confirm or understand a working or final diagnosis, as well as documenting it, 'by systematically considering the various possibilities (differential diagnosis)'.

While some diagnoses are initially hypothesised and then confirmed or not confirmed by investigations, others are established by assessing the person's response to treatment. Balogh et al (2015) viewed diagnosis as a continuous process in which hypotheses are generated and updated using information gathering in four main ways: history and interview; physical examination; diagnostic testing; and referrals. They recognised that this continual process could include refining a working diagnosis after providing treatment, with feedback regarding the treatment's effects also helping to identify when new or different health issues arise. Evaluating treatment in these instances is imperative and the nurse's professional judgement can identify the need for more frequent follow-up or different safety-netting advice owing to the risk of harm (Fletcher et al 2019).

Fletcher et al (2016) suggested that optimal treatment is dependent on the nurse having sufficient time and resources to undertake comprehensive assessment, which can be adversely affected by workload pressures or remote consultation methods. A more effective initial assessment, a systematic approach and appropriate testing to promote informed choice are likely to save time and resources because people can become non-concordant with treatment they have not fully understood. Trueman et al (2010) estimated that £300 million in prescription items were wasted each year in primary care, and although the study is dated it has prompted more recent proposals to address this issue such as improving medicine use, reducing errors and encouraging more cost-effective prescribing (Ewbank et al 2018, Rule and Jones 2021).

Decision-making

A thorough assessment can reduce the risk of harm, non-concordance and facilitate informed choice for treatment options. Awareness of the risks and benefits of treatment options and the ability to articulate these in an understandable way is conducive to shared decision-making (RPS 2021). Using the 'CASE' section of the RAPID-CASE model (Figure 1) to select a product should start with considering whether a prescription is needed, or if there are any alternatives (Gould and Bain 2022).

Is a prescription needed?

While an encounter with a healthcare professional implies the person wishes to have treatment, all options should be considered, including no treatment, onward referral, best practice guidance and lifestyle changes, while considering the risks and benefits, co-morbidities and relevant factors specific to the individual (RPS 2021). Where possible the nurse should provide explanations to support informed choice for the person in their care, while bearing in mind some treatment strategies such as self-care or deprescribing may be in opposition to their preferences. For example, where there is a lack of clinical evidence the nurse may decline a request to prescribe antibiotics for a chest cold, or to increase an opiate prescription.

Cost-effective

When the decision involves a prescription, the choice may be limited by access to specific products in line with local formularies or national guidelines. Prescribed treatment options should have reliable evidence, usually starting with clinical guidelines, and extending to local formularies, which can limit access to products for various reasons including cost-effectiveness. The competency framework (RPS 2021) recommends that national guidelines such as those produced by NICE can be used as a relevant framework for medicines use, and suggests that other guidelines such as local formularies, care pathways or protocols should be used as appropriate. Further considerations include whether the product is available through other means, for example can it be purchased or supplied, and attention should be given to pack sizes and quantities when issuing the prescription.

Appropriate

Appropriate refers to the unique characteristics or preferences of the individual, such as other conditions they may have or medicines that may cause interactions, or the acceptability of the proposed treatment. For example, a teenager may be more likely to accept an inhaled nicotine replacement product than a patch. Further exploration of personal preference, the person's priorities and a focus on reaching a shared decision (RPS 2021) may prevent dissatisfaction or subsequent issues with non-concordance.

Safe

To fulfil their duty of care, the prescribing nurse must keep up to date with Medicines and Healthcare products Regulatory Agency (MHRA) alerts, alongside other medicines alerts, guidelines, research, and best available evidence, as well as taking part in development activities (NMC 2018a, RPS 2021). This awareness supports the prevention of prescribing errors and the provision of clear advice when side-effects or interactions are expected or unavoidable. Safety-netting should be individualised to the person and include specifics as indicated, such as how long before the product should work, what to expect and who to contact if the presenting complaint does not resolve or deteriorates, or when new issues are encountered.

Effective

The effectiveness of the treatment is usually based on recognised guidelines and research. For the nurse, an understanding of the main sources of evidence and most up-to-date research is essential to provide the person in their care with informed treatment options. In addition to being able to justify and explain treatment decisions, it is also incumbent on prescribers to be able to assess how much information to provide and to ensure it is understood. As per the UK Supreme Court ruling in Montgomery v Lanarkshire Health Board [2015] UKSC 11, the practitioner's duty '…is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp…'. The ability to explain effective treatment choices requires the nurse to develop an awareness and interpretation of the available evidence.

Governance

Governance around prescribing decisions also requires attention (RPS 2021). Consent, episodes of care and treatment plans or information provided to the person need to be documented (NMC 2018a, RPS 2021). The NMC (2018c) Code reminds registrants that they should share necessary information only

in the interests of people's safety, while documenting prescriptions or medicines advice avoids polypharmacy and drug errors. For example, an individual prescribed antibiotics for an infected foot wound could be at risk of antibiotic duplication if they were also under the care of a qualified podiatrist who can legally dispense antibiotics without a prescription (MHRA 2014, Health and Care Professions Council 2021). Similarly, an individual might double a prescribed paracetamol dose if they were also taking the medicine as part of a self-care regimen.

Nurses should remember that using recognised reporting systems, observing protocols as appropriate, communicating effectively and working collegiately can preserve safety and promote best practice (NMC 2018c).

Conclusion

When prescribing, suboptimal assessment can cause delays in care, misdiagnosis and prescribing errors. For the nurse prescriber, the use of a model such as the RAPID-CASE can guide decision-making in prescribing and assist the nurse to adhere to the professional dimensions of prescribing practice. Part two of the article continues the exploration of core dimensions of prescribing practice, with a focus on the legal and ethical aspects.

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