Nurse and Midwife
Medicinal Product Prescribing

Clinical Nurse/Midwife Specialist
Registered Nurse Prescriber Survey
Report

Changing practice to support service delivery
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I am delighted to present this report of the clinical nurse/midwife specialist registered nurse prescriber survey. This survey was undertaken in 2013 by the nurse and midwife medicinal product prescribing team, Office of the Nursing and Midwifery Services Director, Health Service Executive with the purpose of identifying the benefits of medicinal product prescribing for clinical nurse/midwife specialists in Ireland.

The findings from the survey indicate the benefits of this expanded role for clinical nurse/midwife specialists, particularly aligned to enhanced patient care and more efficient service delivery in addition to the opportunity presented for continuous professional development.

This is the first published survey of a specific cohort of registered nurse prescribers since the introduction of the initiative in 2007. I am therefore particularly grateful to those clinical nurse/midwife specialists who participated in the survey, and those who kindly submitted the vignettes. It is evident from the overwhelmingly positive survey results that clinical nurse/midwife specialists who are registered nurse prescribers can demonstrate benefits for patients and opportunities for their individual professional development.

The prescribing team is most grateful to the nurses and midwives who responded to both the pilot and main survey and would like to thank and acknowledge the guidance and expertise provided by the following: Dr Sarah Condell, ONMSD Nursing and Midwifery Research Lead, Ms Maureen Flynn, HSE National Lead for Clinical Governance Development, Ms Linda Nugent, Post-Doctoral Researcher Nursing Midwifery Planning and Development Unit / Dublin City University (NMPDU/DCU), HSE Dublin North and Ms Anne McCarthy, Research Officer, Nursing and Midwifery Planning and Development Unit, Galway.

I would also like to extend my sincere thanks to Dr Michael Shannon, Nursing and Midwifery Services Director, HSE, for supporting this publication, and for his ongoing support for the medicinal product prescribing initiative.

Ms Clare MacGabhann
Interim Director of Nursing and Midwifery (Prescribing)
Section 1 Introduction

1.1 Background

Nurse and midwife medicinal product prescribing is a relatively new initiative in Ireland. Irish law was amended in May 2007 to give prescriptive authority to nurses and midwives under specific conditions, with the first prescription written by a Registered Nurse Prescriber (RNP) in January 2008. Currently 177 health service providers (49 acute hospitals and 128 primary and community services) across the four administrative areas of the Health Service Executive (HSE) are implementing the initiative.

To date a total of 1009 nurses and midwives have been funded by the HSE to undertake the approved medicinal product prescribing education programme, of which 642 are registered with the Nursing and Midwifery Board of Ireland (NMBI) as RNPs. This group are from diverse grades, including staff nurses/midwives (n = 316), clinical nurse/midwife specialist (CN/MS) (n = 273) and clinical nurse/midwife manager 2 (n = 178).

From 1 January to 31 December 2013, 408 RNPs reported writing 34,310 prescriptions for 28,045 individual patients involving 25,117 items (ONMSD, December 2013).

While the number of CN/MSs undertaking the nurse midwife medicinal product prescribing education programmes continues to rise, this figure represents only 20% approximately of this grade in Ireland (HSE, 2013).

In light of this data, a survey was undertaken to identify the benefits of prescriptive authority to CN/MSs, with a view to building capacity of RNPs amongst this grade.

This report presents the findings from this survey. The survey took place in spring/summer 2013 and incorporated the following:

- A survey using a web-based online questionnaire www.surveymonkey.ie (Survey Monkey).
- A series of vignettes provided by a number of the respondents. These are presented in Section 6 of this report.

1.2 Methodology

A number of questions were developed by the prescribing team and reviewed by research and clinical governance colleagues. As all CN/MS RNPs were invited to participate in the main survey, the survey was therefore piloted instead amongst Advanced Nurse/Midwife Practitioner RNPs (n = 8) within the voluntary and statutory services of the HSE. The rationale was that these practitioners, whilst not equivalent, also worked in an expanded nursing or midwifery role and some had worked previously as CN/MS. The purpose of the pilot was to test the validity and reliability of the survey instrument. Following the pilot the survey questions were amended to include a total of eleven questions (Appendix 1).

Invitations to participate in the survey were sent by email, following which the survey was distributed on 26 February 2013, with a closing date for receipt of completed survey questionnaires of 15 March 2013. A purposive sample (n = 144) was selected from those CN/MS who were RNPs and registered on the HSE’s Nurse Midwife Prescribing Data Collection, an online monitoring system for RNPs. A reminder email was sent to those who had not responded on the 14th March 2013 to ensure maximum response. A total of 65 responses were received (response rate = 45%). The invitees were informed that all information collected would be reported anonymously and confidentially and that the data collected would be used for a report to the Office of the Nursing and Midwifery Services Director, (ONMSD) and may be subsequently published.

1 Throughout this document, the term “patient” refers to “patient/client/service user”
Respondents were also asked to indicate willingness to work with a member of the nurse midwife medicinal product prescribing team in writing a vignette from their experience as a RNP. Forty-one percent (n = 24) ticked yes, from which 6 were randomly selected. A vignette template was sent to the 6 respondents (Appendix 2).

Descriptive and frequency statistics were used to analyse and interpret the data. Open ended questions and qualitative data were analysed using thematic analysis. Quantitative data is presented in Tables, with skipped questions reported as “Missing Data”.
Section 2  Key Findings

2.1 Introduction

This section reports on the findings from 7 of the 11 questions from the survey. The findings for each question from the survey are presented below. The remaining 4 questions were related to profile details and vignettes.

What is your clinical specialty? e.g. Diabetes, Heart Failure

The respondents were from diverse clinical specialties (n = 25), including mental health 32% (n = 8), cardiac 24% (n = 6), childrens 20% (n = 5), haematology 16% (n = 4), diabetes (n = 4). Three respondents did not answer this question. The clinical areas are presented in Table 1:

<table>
<thead>
<tr>
<th>Clinical Area</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>8</td>
<td>32%</td>
</tr>
<tr>
<td>Cardiac</td>
<td>6</td>
<td>24%</td>
</tr>
<tr>
<td>Childrens</td>
<td>5</td>
<td>20%</td>
</tr>
<tr>
<td>Haematology</td>
<td>4</td>
<td>16%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4</td>
<td>16%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>4</td>
<td>16%</td>
</tr>
<tr>
<td>Tissue Viability</td>
<td>4</td>
<td>16%</td>
</tr>
<tr>
<td>Oncology/radiation</td>
<td>3</td>
<td>12%</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>3</td>
<td>12%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>Renal</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>Intellectual Disability</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>Pain Management</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>Pre-op Assessment</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>ENT</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Infectious Diseases/HIV</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Midwifery</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Breast Care</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Stroke</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Neurology</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>SATU</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>62</td>
<td>95%</td>
</tr>
<tr>
<td>Missing data</td>
<td>3</td>
<td>5%</td>
</tr>
</tbody>
</table>

The majority of respondents (78%) were from the acute sector with the remainder from Primary Community and Continuing Care.
What year did you commence practising as a Registered Nurse Prescriber?

The majority of respondents (63%) commenced practising as a RNP in 2011/2012, as demonstrated in Figure 1:

Figure 1: Year commenced practising as RNP

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Count</th>
<th>Response Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>4</td>
<td>6%</td>
</tr>
<tr>
<td>2009</td>
<td>9</td>
<td>15%</td>
</tr>
<tr>
<td>2010</td>
<td>9</td>
<td>15%</td>
</tr>
<tr>
<td>2011</td>
<td>16</td>
<td>26%</td>
</tr>
<tr>
<td>2012</td>
<td>23</td>
<td>37%</td>
</tr>
<tr>
<td>2013</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td><strong>answered question</strong></td>
<td><strong>62</strong></td>
<td><strong>97%</strong></td>
</tr>
<tr>
<td><strong>Missing data</strong></td>
<td><strong>3</strong></td>
<td><strong>3%</strong></td>
</tr>
</tbody>
</table>

What motivated you to become a Registered Nurse Prescriber?

Respondents were given a list of five choices, and asked to tick the statement most relevant to them. The respondents chose more than one answer for this question. The most commonly chosen option was “Improve patient care” 82%, (n = 49), followed by “Service Need” 47%, (n = 28). This is represented in Figure 2:

Figure 2: Motivation to become a Registered Nurse Prescriber

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Count</th>
<th>Response Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve patient care</td>
<td>49</td>
<td>82%</td>
</tr>
<tr>
<td>Service need</td>
<td>28</td>
<td>47%</td>
</tr>
<tr>
<td>Self-motivated</td>
<td>19</td>
<td>32%</td>
</tr>
<tr>
<td>Career advancement</td>
<td>18</td>
<td>30%</td>
</tr>
<tr>
<td>Another RNP as a role model</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td><strong>answered question</strong></td>
<td><strong>60</strong></td>
<td><strong>92%</strong></td>
</tr>
<tr>
<td><strong>Missing data</strong></td>
<td><strong>5</strong></td>
<td><strong>8%</strong></td>
</tr>
</tbody>
</table>

A total of three respondents selected “Other”, with the following reasons specified:

- Encouraged by ADON as funding might not have been provided in the future
- Asked by consultant
- I was asked to participate by Senior Nursing Staff
Did you experience any delays in registering as a Registered Nurse Prescriber?

A total of 54% (n = 34) experienced delays registering as RNPs while 46% (n = 29) did not. Two respondents did not respond in this section. Respondents were requested to give details of the delays experienced. These have been categorised as follows:

**Collaborative Practice Agreement (CPA)**

- Getting CPA signed off locally by all required stakeholders delayed the entire process
- Completing my CPA was hugely time consuming and difficult.
- A long process to get consultants to sign CPA. They were happy to sign just difficult to get them at the time.

**Drugs and Therapeutics Committee Support**

- Lack of agreement and support from the local D&T committee
- Getting the CPA through the Drugs and Therapeutics committee
- Some delay due to lack of D&T on site
- We didn’t have access to a D&T committee. Once we got this in place and functioning there was no delay.
- Delays encountered in seeking approval for my CPA from the Drugs & Therapeutics Committee
- Delay mainly due to infrequent meeting of hospital D+T committee.
- This was mainly around the formation of the Drugs and Therapeutic committee
- Pharmacy were not helpful in assisting to get drugs through drugs and therapeutics
- Getting CPA drug list approved. Also I was in the first group to qualify so some PPGs had to be finalised before I could register
- Receiving approval from Drugs and Therapeutics

**Time Factor**

- These were related to how busy my role is and also how busy my mentor is. It was difficult to co-ordinate times for us to meet and complete OSLER’s and once they were completed it was difficult to set aside time to finalise my CPA
- Local policy took time to be developed
- Many delays, did not understand the COMPLICATED lengthy process to get registered, took over a year
- Personal Reasons
- I was the first Nurse Prescriber in our area so some work involved in putting policy together etc.

**Lack of managerial support**

- Significant disinterest from higher management and a desire to standardize all mental health prescribers CPAs appeared to be the biggest barrier to swift registration as an RNP locally
- Challenges around processes within the hospital and poor communication
- It took me 3 years to persuade the DON of the benefits of nurse prescribing in my specialist area

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2 Collaborative Practice Agreement (CPA): The CPA is drawn up with the agreement of the RNP, collaborating medical practitioner and the employer outlining the parameters of the RNP’s prescriptive authority (i.e. his/her scope of practice. The principles of professional accountability, responsibility, competence and clinical governance underpin the CPA. The medicinal products listing is approved by the Drugs and Therapeutics Committee and authorised by the director of nursing/midwifery/public health nursing. (An Bord Altranais, 2012)

3 Policies, Procedures and Guidelines
This feedback is reflective of the national experience of implementing nurse midwife medicinal product prescribing. Delays frequently relate to developing the CPA or accessing and/or progressing CPA through D&T committees. This is particularly (but not always) the case when an organisation is supporting a candidate for the first time (Office of the Nursing and Midwifery Services Director, December 2013).

List the top five benefits/efficiencies you have identified as a Clinical Nurse/Midwife Specialist with prescriptive authority

Each respondent was asked to list the top five benefits/efficiencies to them as a RNP.

The responses were qualitatively analysed and common themes identified. The themes were divided into patient care/service improvement and professional development. The most common response was “Enhanced Patient Care, which 27 respondents listed as their top benefit/efficiency. 16 identified it as their second, 11 as their third and 8 as their fifth (total for this category = 62). This would indicate that 100% of respondents identified “Enhanced Patient Care” as a key benefit to them. The next most common benefits/efficiencies identified were “Timeliness” (n = 36) followed by “Streamlining of Services” (n = 20) and Increased Autonomy (n = 20). Table 2 identifies the top five benefits/efficiencies identified.

<table>
<thead>
<tr>
<th>Benefit/Efficiency: Patient Care/Service Improvement</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced patient care</td>
<td>27</td>
<td>16</td>
<td>0</td>
<td>11</td>
<td>8</td>
<td>62</td>
</tr>
<tr>
<td>Timeliness</td>
<td>18</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>36</td>
</tr>
<tr>
<td>Streamlining of service</td>
<td>6</td>
<td>8</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Convenience for patients</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Improved Compliance</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Reduced waiting times</td>
<td>0</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Value for money</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Reduced antibiotic use</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Team collaboration</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit/Efficiency: Professional Development</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased Autonomy</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Empowerment</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Professional Development</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td>5</td>
<td>23</td>
</tr>
<tr>
<td>Role Satisfaction</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Expanded Role</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

Since registering as a Registered Nurse Prescriber, have you identified any challenges to implementing nurse midwife prescribing in your service? If yes, please give details

Forty-two percent (n = 25) of respondents identified challenges while 58% (n =34) stated there were no challenges for them regarding nurse midwife medicinal product prescribing. A further 9% (n = 6) respondents did not answer this question.
Figure 3: Challenges to implementing nurse midwife prescribing

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response count</th>
<th>Response Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>25</td>
<td>42%</td>
</tr>
<tr>
<td>No</td>
<td>34</td>
<td>58%</td>
</tr>
<tr>
<td>Answered question</td>
<td>59</td>
<td>91%</td>
</tr>
<tr>
<td>Missing data</td>
<td>6</td>
<td>9%</td>
</tr>
</tbody>
</table>

The comments relating to this question have been categorised into themes as listed below:

**Multidisciplinary Support**

The most common challenge identified was multidisciplinary support, particularly in the early stages (n = 9). Comments include:

- The main challenge for me was to ensure all of the Consultants in the General hospital setting as well as the Consultant Psychiatrists were on board. However there is an excellent D&T committee in who fully support Nurse Prescribers so I was very lucky.
- Getting GP’s to sign CPA
- Nursing Practice Development has a very limited view about the scope of practice of professional nurses.
- Challenges arose initially due to lack of knowledge re nurse prescribing within the multidisciplinary team however through effective change management addressing concerns these challenges were overcome.

**Drugs and Therapeutics Committee**

Three respondents noted challenges with the Drugs and Therapeutics Committee:

- Setting up of Drugs & Therapeutic Committee delay in prescribing and limitations to drugs allowed on CPA
- D&T will not allow me prescribe any drugs that are not on Hospital Formulary.
- Restrictions placed by the Drugs and Therapeutics committee

**Other**

Other challenges included audit, the Nurse Midwife Prescribing Data Collection System, and record keeping.

- The lengthy process of inputting information into the database puts you off writing out large numbers of prescriptions. It is understandable that this should be something that you might adhere to for the first 12 months but it is extra work and quite time consuming (when most of us are working in very busy and demanding roles), I hope that in the future it becomes something that you adhere to for a ‘probation’ period??
- The self-audit process is also a time consuming aspect, some of the things that I must document in the patients chart each time. It now feels that instead of Nurse Prescribing being a useful addition to my role, it’s become something that is less useful and more cumbersome than I ever expected it to be. I hope that in the future as the Role of Nurse prescriber develops that we move away from such stringent guidelines to practice by.
From your experience as a Registered Nurse Prescriber, would you recommend this role expansion to other Clinical Nurse/Midwife Specialists?

Seventy-nine percent (n = 51) responded yes to this question while 9% (n = 6) responded no, and 12% (n = 8) did not answer the question.

Enhanced patient care, service improvement and professional development were the rationale for those who would recommend the role to other CN/MSs

- **Patient benefits. More considered prescribing, more education re medications.**
- **I believe once you have the support and get established it is an excellent service to have and works out very well as part of the overall assessment in organising an appropriate treatment plan.**
- **Service users with an intellectual disability may have difficulty in verbalising their complex medical/psychiatric needs. Holistic assessments and individualised timely care is required. RNPs within Intellectual Disability are ideally placed to provide this prior to writing a prescription.**
- **Holistic care and better client management of chronic conditions - concordance and adherence improved**
- **Enhances professional development and allows for autonomy of the CNS in their specialist area**
- **Enhanced response to service user need. Increased knowledge and expertise in all aspects of NP not only act of prescribing.**
- **As a CNS it makes my role more holistic and time efficient.**
- **Enhances the care provided to patients by reducing the barriers in obtaining adequate pain relief**
- **As a CNS we already have to have more knowledge and experience than a RGN. Being a RNP enhanced the role allowing the "specialist" nurse broaden her/his thinking. As a CNS we often have built up a close relationship with the patient which is based on trust and professionalism. The patient can respond very positively to this and be more confident and therefore feel more empowered.**

Those who responded “No” identified lack of remuneration or increased workload as their rationale for not recommending the role to other CN/MSs:

- **Too much paper work, too much red tape, too much barriers to getting signed off, very little support from medical colleagues, data collection far too time consuming !!**
- **Too much paperwork, very little support locally, audit processes very slow and tedious. The process makes nurses have lesser prescribing rights to other professionals. It does not promote nursing as an autonomous profession.**
- **Financial incentive is required due to the expertise involved in prescribing role.**

The following comment from a RNP in mental health services demonstrates the advantage of this role for CN/MS:

- **In the area of mental health the nurse patient relationship is particularly important in achieving outcomes; central to this is adopting a collaborative approach to treatment planning. The ability to prescribe has enhanced this collaborative approach as the RNP can now initiate both pharmacotherapies and psychotherapies that are tailored to the individual’s needs.**
Section 3 Discussion

In 2004, the National Council for the Professional Development of Nursing and Midwifery undertook an evaluation of the effectiveness of the role of the CN/MS (NCNM, 2004). It was identified that “nurse/midwife prescribing was regarded as essential for service development by Clinical Nurse/Midwife Specialists”. Ten years later, a total of 255 CN/MSs out of the national total of 1,327 (HSE, 2013) have undertaken the nurse and midwife medicinal product prescribing education programme. The purpose of this survey was to gain an insight into the benefits of prescriptive authority for CN/MSs, with a view to building capacity of RNPs within this group.

The overwhelming response to this survey was positive, and demonstrated that patients/service users were receiving an enhanced service from CN/MSs who are RNPs. The majority of respondents would recommend this expanded role to another CN/MS, due to the potential for enhanced patient care and service improvement. This response demonstrates that CN/MS RNPs are committed to and motivated by the need to provide improved patient care. It is also evident from the survey findings that CN/MSs who become RNPs acknowledge the opportunity for continuing professional development provided by their new and expanded role.

This is a significant factor for services considering introducing nurse midwife prescribing, as the primary motivation identified in this survey is enhanced patient care. (See Recommendation 1).

Challenges identified were mainly due to the process involved in progressing to registration as a RNP, for example delays in developing their Collaborative Practice Agreements, or accessing Drugs and Therapeutics Committees. After registration, challenges identified related to on-going audit and monitoring (see Recommendation 2). A review of the Nurse and Midwife Prescribing Data Collection System was undertaken in 2013 to make the System more user friendly.

This survey demonstrates how the development of this role is having a positive effect on patient care and service delivery. The restructuring of hospital groups and primary care services within the health service reform programme will provide an opportunity for CN/MS RNPs to work across a variety of practice settings. Health service providers would benefit from updated guidance on the process of implementing nurse and midwife prescribing (see Recommendation 3).

The education programmes for nurse midwife medicinal product prescribing are provided in eight Higher Education Institutions (HEIs) across the country, with all HEIs offering blended learning with the opportunity to complete the standalone programme at Level 8, or as part of other postgraduate programmes.

The prescribing team enable health service providers, Directors of Nursing/Midwifery/Public Health Nursing and other stakeholders where CN/MSs are employed by providing assistance for this enhanced role. This support includes facilitating master classes/briefing sessions, guidance with audit and individual assistance as required to build capacity of RNPs amongst this group (see Recommendation 4).
Section 4 Recommendations

In order to build on this positive response to nurse and midwife medicinal product prescribing, the following recommendations have been identified:

Recommendation 1
Prescribing team to engage with Directors of Nursing/Midwifery/Public Health Nursing and relevant stakeholders in order to apprise them of this survey and the findings therein, with a view to promoting nurse midwife prescribing amongst CN/MSs.

Recommendation 2
Directors of Nursing/Midwifery/Public Health Nursing and relevant line managers to support candidate/s to complete CPA and submit to Drugs and Therapeutics Committee within 3 months of completion of the relevant education programme, and to register as a RNP within approximately 6 months of completion of the education programme as per site declaration form.

Recommendation 3
Prescribing team to develop a Toolkit as part of a resource pack to support services introducing nurse midwife medicinal product prescribing.

Recommendation 4
Prescribing team to provide master classes/briefing sessions to promote and build capacity of RNPs amongst CNMSs.
Section 5 Conclusion

The findings from this survey and the vignettes submitted has identified the introduction of nurse and midwife medicinal product prescribing for CN/MSs as overwhelmingly positive. The CN/MSs who are RNPs identified ‘enhanced patient care, timeliness and streamlining of services’ and the opportunity for their own continuing professional development as the top benefits and efficiencies for them since they commenced prescribing of medicinal products. Building capacity of the CN/MSs to become RNPs will further enhance service delivery and improve the quality of care delivery to patients.

The Office of the Nursing and Midwifery Services prescribing team has and continues to support health service providers and CN/MSs in enhancing their role development by undertaking the nurse and midwife medicinal product prescribing education programme and becoming RNPs. It remains for services to examine the specific need for building capacity of CN/MS RNPs within their service.

Clinical Nurse Midwife specialists were asked at the time of completing the questionnaire if they would be interested in submitting an example of how nurse and midwife medicinal product prescribing had influenced a patient’s care and management in their service. The following are examples of the vignettes we received which are reported anonymously.
Section 5 Vignettes
Vignette 1: Pain Management

As part of the pain management round I as a RNP assessed the patient. This lady had a caesarean section under spinal anaesthesia and intrathecal Morphine 150 micrograms and Paracetamol 1 gram intravenous administered in theatre. Patient refused NSAID as she felt she did not require it. On average the pain score for the past 12 hours was 5/10 VAS. During this assessment the patient stated that it was also difficult to breast feed due to the discomfort and pain trying to get out of bed, despite Paracetamol 1 gram 6 hourly and Oxynorm 10mgs (Oxynorm) orally. She stated adverse side effects associated with Diclofenac Sodium in her family. However, she had taken Ibuprofen on a number of occasions without any side effects and no contraindications to administration of ibuprofen were established prior to prescribing.

Following a prescription for Ibuprofen patient achieved a greater than 50% reduction in her pain score. The patient had a reduction in pain score from 7/10 VAS to 1/10 VAS within one hour of prescribing and administration of the drug.

The lady stated that she was now able to get out of bed, lift her baby out of the cot independently and breastfeed her baby without experiencing too much discomfort. Pain score post administration was 1/10 VAS.

Prescribing had improved the overall outcome for patients in my service. Multimodal analgesia is effective for acute pain management.
Vignette 2: Palliative Care

50 year old male patient with an osteosarcoma of his leg. Pain escalating and finding it difficult to go to medical practitioners to get assessed and have medication adjusted according to his needs. I was able to review the gentleman at home, assess him and give him a prescription for the increase in his pain management medication there and then following consultation with my medical mentor and his medical practitioner. The patient was very pleasantly surprised that I was able to assess him, listen to his needs and adjust his medications according to his need. He felt he was being listened to and that his needs were being met promptly and efficiently.

The gentleman had a progressing tumour in his leg that was being treated with morphine sulphate and Pregabalin. He would have to sit in the medical practitioner’s surgery to be assessed and have his medications adjusted. His pain was keeping him awake at night and affecting his appetite and general well being. His mood was low when I visited and he was dreading going to the surgery as he would have to wait and he commented that his prescription was “more often than not incorrect”.

The patient was very pleased with the outcome of our first visit. I have since visited on a number of occasions and adjust his morphine sulphate and Pregabalin upwards according to his needs. He is confident in ringing me and requesting a review at any time. His only disappointment is that other members of the team do not prescribe.

Nurse prescribing has the potential to change the way community palliative care nurses work, for the better. Patients are generally confident in the clinical nurse specialist that visit them on a regular basis and are happy to have the CNS prescribe for them. This usually means no long protracted waits in medical practitioner waiting rooms and that they can pick up their prescriptions more promptly.
Vignette 3: Dermatology

A case sample of a patient with psoriasis is used to explore the scope of the registered nurse prescriber role, including an example of a consultation model; physical assessment to aid diagnosis and treatment of limited/localized psoriasis; and prescribing responsibilities. The integration of these roles with nursing care that promotes communication and concordance can benefit patients with chronic conditions and their families.

Kevin, a 30 year old male, attended the Dermatology nurse-led clinic, new referral from GP, with red scaly plagues involving upper and lower limbs, trunk area not resolved by topical agents prescribed by GP (coal tar and emollient agents), ? Psoriasis for review.

A full assessment of Kevin’s symptoms was made using the Calgary-Cambridge consultation model (Silverman et al, 1998), a structured framework that enables a systematic, consistent approach to the consultation. Bickley and Szilagyi (2003) found the organised approach of the Calgary-Cambridge model enable the nurse to gather patient information through a structured history and physical examination, enhancing the nurse-patient relationship and improving critical thinking.

Diagnosis of psoriasis is made on clinical grounds because there is no specific laboratory test. Kevin had dark red plagues with fine to rough scaling covering a large part of the lesion, and slight elevation, but defined; on elbows, knees and truck area.
Impression: localized psoriasis.

Part of history taking involves finding out what medication, whether prescription drugs, over the counter or complementary medications, are being taken. Kevin reported that he was only using the topical agents prescribed by the GP. They had a little effect initially but no longer effective.

Kevin required stronger topical agents to clear his current psoriasis flare.

Topical vitamin D analogues prescribed:
- Dovobet topically once daily follow-up in 1 month (To body plague psoriasis areas)
- Emollient therapy to enter skin Twice daily
- Avoid soap products

Follow-up in 4 weeks to review treatment regime.

As a nurse prescriber the dermatology CNS was able to complete the cycle of care by prescribing the treatment for the patient and giving adequate information on medication prescribed. Nurses with nurse prescriber competencies working in nurse-led clinics are ideally placed to provide high quality, evidence-based care to meet the needs of the patients.

Kevin attended his four week follow-up appointment, psoriasis improving treatment plan changed as required.
Vignette 4: Paediatric Haemoglobinopathy

A 2 year old girl attended day unit for planned procedure with her mother. Problem with constipation for preceding three months at least. On review with CNS post procedure mum advised that child crying and straining on stooling. Bowels only opening alternate days (stools hard and lumpy). Abdomen on exam, non tender with no hepatospleenomegaly, abdomen distended. Rest of physical exam-Normal.

In view of abdomen appearance and history given stool softener prescribed as above.

Prescribed Lactulose 5ml twice daily orally for one month with planned review after one month.

In view of abdomen appearance and history given stool softener prescribed as above.

Following review one month later, mum advised that daughter having daily soft bowel motions with Lactulose. Daughter no longer crying/straining on stooling. Medication effective and further prescription for Lactulose 5ml twice daily orally given (3/12). Mum happy with effect of medicine and advised to continue with same and to feedback to us again in three months time at next review

Important to question parents on review around daily activities of child and not just specifically around medical condition. May present with simple problem as above with ready solution.
Vignette 5: Psychiatry of Life

New assessment. 79 yr old married lady with psychotic phenomena and associated lowered mood. Extremely distressed. Reluctant to engage with Psychiatrist/Acute Day hospital. Formed therapeutic relationship/developed trust/prescribed anti-psychotic medication, increasing dose until distress and psychotic symptoms were lessened. Mood remained low with associated anxiety-prescribed antidepressant and increased to therapeutic level. Symptoms abated/mood increased/anxieties lessened. Next reduced antipsychotic medications to minimum required/effective level. In conjunction with cognitive interventions, confidence building techniques and behavioural approaches as well as anxiety/relaxation techniques, immediate pharmacological intervention reduced the length of, and the severity of distress she experienced.

Subjectively she felt positive about CMHN prescribing – she felt informed about the medications, their effects and side effects – CMHN was responsive and flexible and monitored medication effectiveness closely and this was reassuring for her.

Care ongoing.

Psychotic phenomena with associated lowered mood. Deteriorating mood associated with stress and poorer physical health. Husbands health concerns more overt. High expressed emotion within the family, adult children all concerned but living abroad. Good engagement from primary care/support services.

Positive intervention. More immediate lessening of distress very positive. Having a responsive and intensive clinical presence, in whom she trusted, provided greater reassurance for client and family. Involvement in reduction of medication planning proved empowering. Information about medications given verbally and in written form reduces anxieties around pharmacological intervention. Not having to meet directly with a Psychiatrist was important to this client- less issues @ stigma associated with nurse prescribing in this instance.

Positive feedback. Client felt involved and subjective impact and effectiveness was seen as important. We are presently negotiating further reduction in anti-psychotic medication. Service seen as flexible and responsive which provided client and her family with greater reassurance.

The development of a therapeutic relationship and trust with the prescriber is as important as the actual prescribing itself. Nursing clinicians are well versed in these skills and this highlights and enhances nurse prescribing suitability and the continued need for its promotion.

I feel it important to recognize the importance of supportive medical colleagues within our teams, whose experience and skills supplement nurse prescriber’s assessment and intervention skills.
**Vignette 6: Respiratory**

Patient attending my nurse led outpatient clinic. Following spirometry and assessment of patient a new diagnosis of Asthma is confirmed. Patient is initiated on appropriate inhaled medication. The drug of choice and devices available are reviewed and prescription is given to patient.

Patient, who has no Medical Card, is delighted that they don't have to see GP and pay for prescription to be written.

Patient also feels happier as CNS has explained use, side effects and outcomes fully. Patient’s condition was treated appropriately. On review, all symptoms had resolved and patient felt in control of their condition. No alterations were required to initial treatment

Patient, who has no Medical Card, is delighted that they don't have to see GP and pay for prescription to be written.

Patient also feels happier as CNS has explained use, side effects and outcomes fully. Medical Card patients still have to attend GP for prescription, as pharmacies will not issue medication without same. Short course of treatment is not available in inhalers.
References


Health Service Executive (2013) *Health Service Personnel Census*. Dublin: HSE


### Appendix 1 Survey Questions

1. **Name**

2. **What is your clinical specialty? E.g. Diabetes, heart failure**

3. **What year did you commence practising as a Registered Nurse Prescriber:**
   - [ ] 2008
   - [ ] 2009
   - [ ] 2010
   - [ ] 2011
   - [ ] 2012
   - [ ] 2013

4. **What motivated you to become a Registered Nurse Prescriber? Please tick the statement(s) most relevant to you:**
   - [ ] Another RNP as a role model
   - [ ] Career advancement
   - [ ] Improve patient care
   - [ ] Self motivated
   - [ ] Service nee
   - [ ] Other (please specify)

5. **Did you experience any delays in registering as a Registered Nurse Prescriber?**
   - [ ] Yes
   - [ ] No
   - Comment

6. **List the top five benefits/efficiencies you have identified as a Clinical Nurse/Midwife Specialist with prescriptive authority:**
   1. __________________________________________
   2. __________________________________________
   3. __________________________________________
   4. __________________________________________
   5. __________________________________________
7  Since registering as a Registered Nurse Prescriber, have you identified any challenges to implementing nurse midwife prescribing in your service? If yes, please give details.
   ☐ Yes
   ☐ No
   Comment

8  From your experience as a RNP, would you recommend this role expansion to other Clinical Nurse/Midwife Specialists?
   ☐ Yes
   ☐ No
   Please give reasons for your answer here

9  As part of this survey, we will include some examples/vignettes of how prescribing by a Clinical Nurse/Midwife Specialist RNP has benefitted patient care and management. Would you be interested in working with one of the nurse midwife medicinal product prescribing team in writing a patient story from your experience as a Registered Nurse Prescriber? If yes, a member of the team will follow up with you.
   ☐ Yes
   ☐ No

10 Data from this survey will be used in a report and may be used in a journal publication. All information will be presented anonymously and confidentially. If you do NOT wish your data to be included in a journal publication please indicate below.

11 Additional information
Appendix 2 Template for Vignettes

Nurse and Midwife Medicinal Product Prescribing Clinical Nurse/Midwife
Specialist Registered Nurse Prescriber Survey Vignettes

Your Name (for administrative purposes only): _________________________________________
Your Clinical Area: __________________________________________________________________

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<tbody>
<tr>
<td>1.</td>
<td>Give an example of a positive prescriptive episode of care, preferably involving feedback from the patient/client/service user:</td>
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<tr>
<td>2.</td>
<td>Describe the situation</td>
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<td>3.</td>
<td>What was the outcome of the prescriptive episode?</td>
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<td>4.</td>
<td>What feedback did you receive from the patient?</td>
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<td>5.</td>
<td>Any other comments?</td>
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