British Association of Critical Care Nurses position statement on prescribing in critical care

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ABSTRACT

Background: Nurses in the UK are now one group of non-medical staff who can prescribe. This practice is evolving for critical care nursing staff who care for critically ill patients during their stay in hospital through ward and outpatient follow-up after admission to critical care.

Aim: The purposes of this paper were to present existing information regarding prescribing to support nurses in critical care currently prescribing and to inform those who are intending to prescribe.

Methods: To develop the position statement, a search of the literature was conducted using key databases. To ascertain the current level and type of prescribing in critical care, a short questionnaire was sent by email to British Association of Critical Care Nursing members, and the results of this are presented in Appendix A.

Outcomes/Results: Evidence was found in relation to the history, context in critical care, educational requirements and issues of consent related to non-medical prescribing.

Conclusions: The position statement is based upon evidence from the literature, National Health Service policy and the Nursing and Midwifery Council regulations. It takes account of the critical care patient pathway before, during and after an admission to critical care.

Key words: Independent prescriber • Nursing • Professional practice • Supplementary prescriber critical care nursing

1. Nurse prescribing should only be implemented to provide greater access and to improve care for the critical care patient.
2. The need for critical care prescribing will vary according to the size, type, location of the critical care unit and case mix of patients. This includes:
   - The follow-up of critical care patients in ward areas,
   - The role of critical care outreach nurses in caring for acutely ill patients in ward areas,
   - Formal and informal follow-up of patients after they have left hospital.
3. It must not be used as a substitute for poor medical prescribing practice.
4. It must adhere to the Nursing and Midwifery Council (NMC) standards for nurse prescribing:
   - The employer must ensure (as per NMC) that the individual has an appropriate level of competence in clinical assessment for the patient group for whom they will be prescribing.
   - There must be appropriately designated support by a medical supervisor and supervision to provide minimum support as advocated by the NMC. However, because of the complex environment of critical care, there will be a need for additional and ongoing supervision.
5. Current and future critical care prescribers should audit and evaluate their practice.
6. Nurse prescribing for critical care patients should be undertaken only by choice of the individual nurse and not because of pressures of service delivery.
7. Critical care nurse prescribers should seek ongoing supervision and continuing professional development.

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INTRODUCTION

As one of the main national organizations for critical care nurses in the UK, the British Association of Critical Care Nursing (BACCN) provides leadership, educational opportunities and support for nurses within the field. This is achieved through many activities including the formulation of position statements that are relevant to the everyday practice of critical care nurses. Recent changes in legislation have meant that the number of nurses in the UK who can currently prescribe has increased. Not surprisingly, the body of literature in this area has also expanded; however, very little is written in relation to the practice of prescribing in critical care. The aim of this project was to develop an informative resource for critical care staff based on the best current available evidence. Consequently, a group of experienced critical care nurses with an interest and expertise in the area of prescribing were convened by the BACCN to form a working party with the purpose of developing a position statement and guidance for critical care nurses who are currently prescribing or who intend to commence this practice in the future. The content in this statement refers specifically to adult patients.

METHODOLOGY

To systematically gather evidence and facilitate the development of the position statement, a number of bibliographic databases were searched. These were Medline, CINAHL, Cochrane database, Department of Health (DoH) and the National Research Register. To further guide the search, the following terms were used: nurse prescribing, non-medical prescribing, critical care, intensive care and education. These terms were combined to extend the range of the search. To focus the scope of the search parameters, other factors included restricting papers to the English language and to human subjects and papers published within the past 15 years as non-medical prescribing was not practiced prior to this time limit. Papers were restricted to the UK only as the statement aims to support non-medical prescribing in the UK. Ten research papers were found relevant to non-medical prescribing, and one of which is relevant to critical care. Other evidence found relates to National Health Service (NHS) policy, the Nursing and Midwifery Council (NMC) and general commentary related to the non-medical prescribing debate. The literature was then reviewed through the following categories:

- Background and history of nurse prescribing in the UK.
- Context.
- Education.
- Consent and capacity.
- DOH: policy and other professional documents.

The methodology also included a short questionnaire sent by email to nurses with email contact address on the BACCN database. The results of this questionnaire can be seen in Appendix A.

Background and history of nurse prescribing in the UK

From spring 2006, qualified extended formulary nurse prescribers and pharmacist independent prescribers have been able to prescribe any licensed medicine including some controlled drugs for any medical condition. Nurses in the UK have been fighting for this for over 20 years. Following 10 years of lobbying and pilot work (DoH, 1989), nurses gained the ability to prescribe in 1999 (DoH, 1999a, NHSE, 1998); this enabled district nurses and health visitors to prescribe from a very limited Nurse Prescriber's Formulary of mainly dressings and appliances. However, the relatively new labour government wished to modernize the NHS further and introduced a series of policy documents in support of non-medical prescribing. Making a difference (DoH, 1999b) set the direction by including the development of new roles for nurses. The NHS plan (DoH, 2000a) emphasized fundamental changes in the way health care services were to be organized and delivered and to be centred around the needs of patients. Additionally, the chief nursing officer outlined '10 key roles for nurses' including the prescribing of medicines and treatments. Specific targets were set stating that by 2001, approximately 23 000 nurses would be able to prescribe a limited range of medicines (DoH, 2000a).

In March 2000, the main recommendations of the Review of Prescribing, Supply and Administration of Medicines (DoH, 1999a), commonly known as the Crown Review, were accepted. This identified two categories of prescriber, 'dependent' and 'independent', and led to supplementary and extended formulary nurse prescribers. Supplementary prescribers are permitted to prescribe any drug from the British National Formulary, provided the prescription is directed by a clinical management plan (CMP), developed for an individual patient following diagnosis by a medical practitioner (DoH, 2003). This proved valuable in the care of the long-term chronic patient, but supplementary prescribing has not been seen as relevant in acute settings. By contrast, independent prescribers are managed through the Nurse Prescribers Extended Formulary (NPEF), which encompasses four therapeutic areas: minor injuries, minor ailments, health promotion and palliative care. The NPEF has been revised and expanded to cover emergency and primary care.

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In addition to the prescribing legislation, a further review by the DoH (2000b) enabled nurses to administer medicines using a patient group direction (PGD).

Maintaining a formulary to keep pace with prescribing practice proved impossible and lead to a reliance on PGDs and the use of supplementary prescribing to meet patient need. A further refinement of non-medical prescribing was therefore required. The Medicines and Human Use (Prescribing) (Miscellaneous Amendments) Order (DoH, 2006a, 2006b) has enabled nurses who have successfully completed an independent prescribing course to prescribe any licensed medicine, including some controlled drugs (DoH, 2007), for any medical condition within their clinical competence.

The extension of prescribing rights has been extended to pharmacists and other allied health professionals (e.g. chiropodists and physiotherapists) who are also eligible to train and become supplementary prescribers (DoH, 2006a, 2006b). Developments such as these aim to ensure that patients receive medicines in a timely and efficient manner. Changes in the way patients can receive their medicines have progressed rapidly over the past 3 years. A combination of independent, supplementary prescribing and PGD's are now used to give medicines to patients. This has caused many clinicians confused over both the specific uses of these methods and the terminology used. Table 1 provides summary of these methods and a glossary of terms.

The context of nurse prescribing

As nurse prescribing is now being undertaken in different NHS settings and specialities, evaluations of prescribing practice are able to illustrate the views of nurse prescribers and patients. Most of the studies to date do reflect that the majority of nurse prescribing is currently carried out in primary care settings (Courtenay *et al.*, 2007). Early studies examining the prescribing practices of nurses have found that nurses are still not fully prescribing after completing a prescribing course (Larsen, 2004, While and Biggs, 2004; Holmes, 2006). Reasons cited for this are as follows:

- Inappropriate selection of staff, problems in accessing prescription pads, lack of peer supervision and inadequate knowledge of pharmacology (Larsen, 2004).
- Lack of doctors willing to act as mentors and provide guidance and supervision during and after the prescribing course (Holmes 2006).
- Restrictions to the formulary hindering community practice (While and Biggs, 2004).

Later work by Courtenay *et al.* (2007) and Latter *et al.* (2005) concluded that most nurses were prescribing infrequently. In the study by Latter *et al.* (2005), two thirds of respondents were based on primary care settings, and prescribing was limited to mainly skin conditions, family planning and soft tissue injuries. This study also found that nurses felt that the limited formulary at this time restricted prescribing practice. Concerns were highlighted by respondents over limitations in nurses' history taking, assessment and diagnostic skills. These same findings of restricted access to the prescribing formulary and limits in patient assessment are expressed by Fairley (2006) in relation to critical care.

Positive aspects of prescribing are described as improved communication between professionals and patients and improved patient care by quicker access to medicines (Bradley and Nolan, 2007). In relation to risk issues, nurse prescribers felt that having a prescribing qualification validated the prescribing 'by proxy' they had carried out before the course (Bradley *et al.*, 2005). In relation to the views of patients, a study by Berry *et al.* (2006) found that patients who had not yet experienced nurse prescribing would in general be positive about nurses prescribing for them.

With regard to the impact prescribing had on workload and resources, some nurses felt that taking on a prescribing role added to and conflicted with other nursing demands on their time (Bradley *et al.*, 2005). Nolan and Bradley (2007) explored the views on prescribing and workload of nurses from mental health and general nursing backgrounds. Different perspectives emerged; nurses from general areas viewed the ability to prescribe as enhancing efficiency and resources, whereas mental health nurses felt that it would benefit clients with improved access to care, choice and information.

One evaluation of independent nurse prescribing in secondary care in an elderly care setting showed improved patient care and comfort by better and quicker access to medicines (Clegg *et al.*, 2006). This study also found that independent prescribing supported nursing staff and acutely ill patients as nurses were able to prescribe in the absence of medical staff, ensuring patients receive treatment and care without delay. This article can relate to critical care units and critical care outreach teams in ward areas, describing the advantages of being able to prescribe and respond to the patient's needs in the absence of medical staff when patients are acutely unwell. The prescribers in this article describe that the success of non-medical prescribing is because of being well supported by a robust trust governance programme for this (Clegg *et al.*, 2006). A study by Avery *et al.* (2007) also suggests that this approach is necessary for successful prescribing practices. Conversely, in other research studies,

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Table 1 Glossary of terms associated with non-medical prescribing*

Term	Definition
Administration	To administer a medicine by either introduction into the body, whether by direct contact with the body or not (e.g. orally or by injection), or by external application (e.g. application of an impregnated dressing)
Independent prescribing	Prescribing by a practitioner (e.g. doctor, dentist, nurse, pharmacist) responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing. Within medicines legislation the term used is 'appropriate practitioner'. Independent prescribing provides a Patient Specific Direction via a traditional prescription the patient might take to a pharmacist for supply or via a prescription chart as used in an inpatient setting. To be a prescriber, pharmacists and nurses must first identify a patient need for access to medicines that cannot be met by a doctor. The individual must then successfully complete further training and supervised practice before they can register their qualification with the appropriate professional body. There is a consultation in progress regarding the extension to allow independent prescribing of any controlled drug from schedules 2, 3, 4 and 5 by nurse and pharmacist independent prescribers.
NHS Prescription	An authorisation for the supply of medicines (not necessarily a prescription only medicine (under NHS Acts for a named individual (i.e. at public expenses except to the extent a patient charge is payable)
Patient Group Direction (PGD)	A written instruction for the sale, supply, and/or administration of named medicines in an identified clinical situation. It applies to groups of patients who may not be individually identified before presenting for treatment. The PGD provides a framework for the supply and/or administration of medicines by a range of specific health care professionals, without the need for an individual prescription and includes the administration of controlled Drugs (DoH, 2007). The individuals who are working under the authority of a PGD must be named on the PGD and have signed it. The supply and administration of medicines under a PGD should be reserved for those limited situations where this offers an advantage for patient care without compromising patient safety, and where it is consistent with appropriate professional relationships and accountability. The PGD fits best within services where medicines use follows a predictable pattern and is less individualised and where the individual might only be required to administer or supply a very limited range of medicines. The use of a PGD is not a form of prescribing, and requires no additional formal qualification, although health care professionals who provide care through a PGD must be appropriately trained and understand the responsibilities placed upon them. Organisations that support the use of a PGD have a responsibility to ensure that only fully competent, qualified health care professionals use them.
Prescribe	To authorise in writing the supply of a named medicine (usually but not necessarily a prescription only medicine) for a named patient.
Prescription	A written (signed) authorisation for the supply of medicines
Supplementary prescribing	A voluntary prescribing partnership between an independent prescriber and a supplementary prescriber, to implement an agreed patient specific clinical management plan (CMP) with the patient's agreement. It is designed to enable a supplementary prescriber to take on the medium- to longer-term management of an individual patient. Following agreement of the CMP, the supplementary prescriber may prescribe any medicine for the patient that is referred to in the plan, until the next review by the independent prescriber. There is no formulary for supplementary prescribing and no restrictions on the medical conditions that can be managed under these arrangements. Supplementary prescribers can prescribe controlled drugs and unlicensed medicines in partnership with a doctor. Supplementary prescribing was introduced in April 2003 for nurses and pharmacists. It was extended to physiotherapists, chiropodists/podiatrists, radiographers and optometrists in May 2005. All practitioners must obtain a specific qualification and register this with the appropriate regulatory body in order to become a supplementary prescriber.
Supply	To supply a medicine to a patient/carer for self administration

NHS, National Health Service.

*Information has been taken from DoH, 1999a, Review of Prescribing, Supply and Administration of Medicines – Final Report, London.

nurses felt that lack of organizational support added to workload (Bradley *et al*., 2005).

Prescribing in critical care

The need for non-medical prescribing in critical care areas and for acutely ill patients in ward areas has been considered (Dawson, 2001; Adam, 2004). Such arguments are supported by developments in the organization and management of critically ill patients following the patient care pathway to general wards and follow-up care (DoH, 2000c, 2005). Fairley (2006) audited her own practice of prescribing in a surgical high dependency unit. The factors she describes that affect nurse prescribing in this setting were diagnostic reasoning, insufficient opportunities to allow for learning and reflection and the prescribing practice of the individual clinicians. Restrictions to the formulary of independent prescribers at the time of this audit also hindered practice, and Fairley (2006) advocated an extension to the whole formulary to improve this. A major challenge to becoming an independent nurse prescriber is the acquisition of effective clinical reasoning and diagnostic skills (Fairley, 2006; Avery and James, 2007). A challenge to prescribing for critical

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care patients is the complexity of critically ill patients who may have several underlying diseases. Patients are admitted to critical care units from all specialities with a variety of clinical conditions and underlying diseases, leading to a varied case mix. Added to this, the critical care patient may be developing sepsis or have multisystem failure. Acute and sudden changes in the critical care patient's condition require rapid assessment by experienced staff. The NMC is clear in stating that nurses should only prescribe within their speciality and competence (NMC, 2006). The complexity of patients in general critical care units, who are often receiving many drugs, some of which can be potent such as inotropes, creates multifaceted situations. Only experienced nurses undergoing advanced practice would be able to support prescribing in this area.

A prerequisite for independent prescribing is the ability to competently undertake a clinical assessment and make a diagnosis in order to be able to treat conditions. For critical care nurses, the framework for Advanced Practice in Critical Care (DoH, 2006c) will provide this training under the supervision of a consultant intensivist. This framework document does describe the need for prescribing as a necessary part of the role. Avery and James (2007) suggest that nurse prescribing must be part of advanced nursing practice incorporating training in assessment, diagnosis and clinical decision-making. The role of advanced practice is promoted as necessary for the future development of changing roles in critical care (DoH, 2005). This has been partly driven by the potential reduction in junior doctor hours to provide appropriate and timely care to patients. The numbers of such roles and appropriate remuneration for extended skills are still unclear. However, the value of such roles needs to be carefully thought out in relation to the type, size, case mix and nurse patient ratios of the critical care area they are applied to. It can be argued that junior doctors in critical care are less experienced in managing complex patients, and therefore, the use of experienced nurses' skills is to the patients' benefit (Richmond, 2005). Conversely, junior medical staff need the experience of prescribing for complex patients and will not be able to gain such experience if nursing staff take on this role. What is clear is that nurses should not undertake prescribing because of poor medical prescribing practice (Avery and James, 2007). The standards for any prescriber, medical or non-medical, must be the same, and nursing staff must have the relevant indemnity to cover any broadening of their practice. Smaller units, such as small district general hospitals with difficult access to medical staff, particularly out of daytime hours, may benefit more from nurse prescribing than larger units, which have adequate continuous medical cover. The usefulness of one lone prescriber in a unit has to be assessed if access to prescribing is a continual requirement for the clinical area. The individual will still require access to senior medical and pharmacy colleagues for advice and support. Non-medical prescribing extends to other professions within the critical care team. Pharmacists in critical care have implemented supplementary prescribing, and describe the practice as enhancing team work and patient care, and positively utilizing the skills of different team members (Tomlin, 2005).

Prescribing by the critical care outreach team

The remit and skills of critical care nurses now extend beyond traditional critical care units, as critical care outreach, or in formal follow-up clinics (Adam, 2004). The problems of prescribing in these situations are similar to those within units. Ward-based nurses may be managing acutely unwell patients with complex conditions, while the critical care outreach nurse is a visitor to the general wards. There needs to be some element of negotiation within hospital trusts, departments and the parent teams of the patient in agreeing to outreach teams assessing, diagnosing and prescribing independently for such patients. Critical care units need to explore the governance and legal aspects for nurses potentially prescribing for patients not currently under the care of the critical care unit. Prescribing through PGDs may help in assisting critical care outreach nurses in delivering the medications necessary for immediate resuscitation such as intravenous fluids and oxygen. However, achieving consensus on PGDs may be time-consuming and potentially elusive when engaging all consultant clinicians responsible for patients across an acute hospital.

The BACCN questionnaire: current levels of prescribing

To elicit the number of critical care nurses who had undertaken a prescribing course and were currently using this qualification, a short questionnaire was sent by email to all nurses with email contact on the BACCN database. Although the BACCN database does not have email contact for all members, it allowed for a 'snapshot' view of current prescribing practice in critical care. This did demonstrate that currently very few practitioners are prescribing in critical care, as shown in Appendix A.

Educational standards for nurse and midwifery prescribers

There have been a number of amendments to medicine legislation (HMSO, 2006) recently. In response to this,

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the NMC has produced standards for nurse prescribing (NMC, 2006). Nurses who wish to prescribe must undertake an educational programme in an educational institution approved by the NMC. The NMC provides the broad generic competencies/standards to support the delivery of the nurse prescribing educational programme (NMC, 2006) and they are the regulatory body that provides the nurse prescriber validation to the higher education institutes (HEI), thereby making them approved education institutes (AEIs) (Table 2).

The length of the educational programme for nurse independent/supplementary prescribers shall be a minimum of 26 days, with an additional 12 days of supervised learning in practice (NMC, 2006). All nurses must undertake both independent and supplementary elements of the programme. The AEIs provide the educational framework to equip the practitioner with the necessary competence to provide the knowledge and skills required of a nurse prescriber. Slight variation exists with the requirements set out by the NMC depending on the interpretation of the standards by the AEI. Local examples from members of the working group included:

- Didactic teaching, 1 day/week for 26 weeks plus 12 days workplace (90 h) supervised practice.
- Self-directed study: 12 weeks direct study (1 day/week) plus (90 h) workplace assessment.
- Blended learning: mix of both with an increase in 'web'-based/DVD study.

The nurse prescriber has a requirement to provide evidence of competence and successful completion of the following assessments:

- Portfolio, i.e. rationale for prescribing decisions and evidence of numeracy skills and writing prescription.
- Practical OSCE in a simulated learning environment or video consultation in a live setting.
- Satisfactory completion of the period of practice experience, which is verified by the designated medical practitioner (DMP).
- Written examination to test pharmacological knowledge, and the pass mark for which is 80%.
- Numeracy assessment that requires a 100% pass mark.

(Summarized from the NMC, 2006, Standards of Proficiency for Nurse and Midwife Prescribers).

The educational programme cannot be an HEI only event but should reflect the requirements of all stakeholders (NMC, 2006). The nurse prescriber has a responsibility under their ethical code of conduct to self-assess their confidence and competence (NMC, 2004). A standard framework for continuing competence is required, and the NMC dictates that this is at first-degree level. The National Prescribing Centre (2006) standards mirror the NMC standards and again state that the course must be delivered academically at first-degree level, but there are no standards to assess the numeracy or practical component competency, and this appears to be left to the subjective interpretation of individual stakeholders. Avery and James (2007) express concerns over the educational stand-alone training modules that are currently offered and lack of pharmacology knowledge by nurses. They suggest that the skills in assessment, diagnosis and clinical decision-making should be integral to training courses. To ensure that the nurse prescriber is 'fit for practice', most trusts provide a competency framework under their governance arrangements, and the most common requirement dictates that prescribing must be included in the job description to be protected under vicarious liability, followed by an approval to practice document. Critical care nursing staff may be required to prescribe to patients in units, the wards or follow-up clinics. This and the level 2/3 case mix are such that further local supportive processes may have to be agreed and

Table 2 Nursing and Midwifery Council standards nurses and midwives must meet for prescribing training*

Minimum academic standard should be no less than first degree level.
Must be a registered first level nurse, midwife and/or specialist community public health nurse.
Have at least three year's experience and be deemed competent by their employer to undertake the programme. Of these three years, the year immediately preceding the application to the programme must have been in the clinical field in which they intend to prescribe.
Provide evidence via the Accreditation of Prior Experiential Learning (APEL) process of their ability to study at minimum of first degree level
The nurse must have written confirmation of their employer's support to undertake the programme
And written confirmation from the programme lead about selection onto the preparation of prescribers education programme.
And a designated medical practitioner who meets eligibility criteria for medical supervision of nurse prescribers and who has agreed to provide the required term of supervised practice.
Nurses must be competent in history taking, physical assessment and diagnosis and either provide evidence of this or undertake an educational programme prior to commencing the nurse prescriber's programme.

*Information has been taken from the NMC, 2006, Standards of Proficiency for Nurse and Midwife Prescribers.

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employed by the DMP to safeguard the nurse prescriber practising within different settings. The common denominator for learning outcomes and competencies provided by all AEIs is that they all meet standards set by NMC, Health Profession Council and Royal Pharmaceutical Society.

Registerable qualifications for nurse prescribers

Nurses must not prescribe until they have successfully completed an approved programme and recorded their qualification with the NMC. With the evolvement of legislation related to nurse prescribing, the types of registerable qualifications have changed. The original district nurses and health visitor independent nurse prescribers are now known as community practitioner nurse prescribers and are registered with the NMC as V100 prescribers. The extended formulary nurse prescribers are now known as nurse independent prescribers and are registered as V200 prescribers, and the initial supplementary prescribers are known as nurse independent supplementary prescribers and are registered as V300 prescribers (Table 3).

The entry codes V100, V200 and V300 indicate from which formulary the nurse is qualified to prescribe:

- Community practitioner nurse prescribers (V100).
- Nurse independent prescribers (V200 only).
- Nurse independent/supplementary prescribers (V300) (NMC, 2006).

Nurses may be eligible to prescribe from the Community Practitioner Formulary only (V100 only) or may do so in addition to being a nurse independent/supplementary prescriber (V200 and V300). However, it is not possible to prescribe as a supplementary prescriber without first undertaking preparation to be a nurse independent prescriber. While in the past nurses may have completed the V200, this qualification is no longer offered separately. Nurses who currently have a V200 qualification only are being encouraged to top-up to a V200/V300 qualification. The current numbers of nurses now registered with the NMC can be seen in Table 4.

Table 3 Registerable qualifications for nurse prescribers (From May 2006)*

Previous Definition	Current Definition
District nurse/health visitor formulary nurses and any nurse undertaking a V100 prescribing programme as part of a Specialist Practitioner Qualification	Community practitioner nurse prescribers (V100)
Extended formulary nurse prescribers	Nurse independent prescribers (V200 only)
Extended/supplementary prescribers	Nurse independent/supplementary prescribers (V300)

*Information has been taken from the NMC, 2006, Standards of Proficiency for Nurse and Midwife Prescribers.

Consent in relation to prescribing

CMPs used for supplementary prescribing require evidence that the patient has consented to this form of prescribing, and this may be further elaborated upon by local policy. The changing nature of critical care has meant that critical care nurses find themselves prescribing in a variety of settings ranging from the intensive care unit, ward areas and follow-up clinics. Given the variety of patients, it is apparent that the patient's capacity to give informed consent will vary greatly depending on their physiological and psychological status. Consent may be given verbally, written or implied by co-operation; equally, it can be withdrawn at any time, providing the patient has capacity to do so (NMC, 2006a). All forms of prescribing must be subject to consent, and this is reflected in recent studies, which indicate that nurse prescribers enhance care by providing patients with information, including them in decision-making and enhancing quality care (Latter *et al.*, 2005; Avery *et al.*, 2007; Bradley and Nolan, 2007; Nolan and Bradley, 2007). The duty to gain consent is protected by the tort of battery. Failure to ensure that a patient has been given sufficient information to give informed consent can give grounds for an action of negligence (McLean, 2006). The NMC (2006b) advises that for an agreement to be effective, then adequate information about the nature, purpose, associated risks and alternatives must be given to the patient. The NMC clarifies that during emergencies where treatments are necessary to preserve life, you may act without consent, providing that you are acting in the patients' 'best interests' (NMC, 2004).

The recent introduction of the Mental Capacity Act (2005) indicates that before a practitioner can safely proceed to prescribe under the auspices of best interests, consideration must be given to the following five principles as outlined in the Mental Capacity Act:

- A person must be assumed to have capacity unless it is established that he lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

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Table 4 Nurses and midwives with a recorded qualification for prescribing*

Prescribing qualification			2006/2007	
Community practitioner nurse prescribers			1708	
Nurse independent prescribers			35	
Nurse independent/supplementary prescribers			3415	
Total			5158	
Total on the register	**2003/2004**	**2004/2005**	**2005/2006**	**2006/2007**
Community practitioner nurse prescribers	30 599	31 914	33 069	34 000
Nurse independent prescribers	1497	1618	1653	1648
Nurse independent/supplementary prescribers	1457	4151	7181	10 750
Total	33 553	37 683	41 903	46 398

*The Nursing and Midwifery Council (NMC) includes the numbers of nurses and midwives with a registerable prescriber qualification in its annual statistical analysis of the register from 2003. The table indicates the number of nurses and midwives who have recorded a qualification for prescribing up to 31 March 2007 (NMC Annual Statistics 2006–2007, http://www.nmc-uk.org/).

- Any act carried out or decision made for or on behalf of a person who lacks capacity must be carried out or made in his best interests.
- Before the act is carried out or decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of actions.

(The Mental Capacity Act, 2005, Chapter 9, Part 1, Persons who lack capacity).

Consultation with the patient's family or significantly others to establish a patient's wishes has been established as good practice for some time. The introduction of the Lasting Power of Attorney as outlined in the Mental Capacity Act (2005) and legally enforced from 2007 in England and Wales has for the first time given the legal right for one person to consent on behalf of another adult. The degree to which the nominee of the Lasting Power of Attorney can make decisions on behalf of the incapacitated patient would be outlined in the Lasting Power of Attorney document but can extend to the refusal of life-sustaining treatment. However, the nominee of the Lasting Power of Attorney is also legally obliged to abide by the principles of the Mental Capacity Act (2005) and as such must demonstrate that they too are acting in the best interests of the patient.

Regardless of the patient's legal right to consent the practitioner should attempt to gain the patient's informed consent before proceeding. Patients detained under relevant mental health legislation have the same rights to consent or decline treatment as other patients, with the exception to medications prescribed to treat the mental condition for which they have been detained (NMC, 2006). Unless as stated in the Code of Practice for the Mental Health Act 1983 (HMSO, 1999), it is reasonable to assume that the physical disorder is a symptom or underlying cause of the mental disorder for which they have been detained. The code acknowledges that this can be a difficult area and recommends that the practitioner seeks legal advice if they are not clear on how to proceed.

CONCLUSIONS

Evaluation of the practice of nurse prescribing to date has demonstrated that there are areas of training and implementation, which need to be improved upon and incorporated into defined advanced practice (Avery and James, 2007). There are relatively few nurses independently prescribing in critical care areas including the care of patients in ward areas by critical care outreach teams: the main practice is that of the use of PGDs and supplementary prescribing (Appendix A). The BACCN has provided a position statement to aid current and future nurse prescribers in critical care to ensure that the practice is undertaken safely and for the benefit of patients. Continued evaluation of prescribing practice in critical care is necessary to improve this role in critical care.

DISCLAIMER

Please note that the authors made every effort to ensure that the information in this position statement and review was accurate at the time of going to press. Readers are strongly advised to regularly check for any amendments from the DoH or NMC as non-medical prescribing is a dynamic area of practice where advice and standards are frequently updated.

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WHAT IS KNOWN ABOUT THIS TOPIC

- Nurses are now eligible to act as independent prescribers following appropriate education and training.
- The extent of independent and other aspects of prescribing by critical care nurses was unknown.

WHAT THIS PAPER ADDS

- An overview of the current literature related to prescribing.
- Currently the number of critical care nurses independently prescribing is low.
- Guidance for critical care nurses who are currently undertaking or intending to prescribe for any patient who presents on the critical care pathway, including ward care by critical care outreach services.

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APPENDIX A

Results of a questionnaire on current practice of non-medical prescribing in critical care settings

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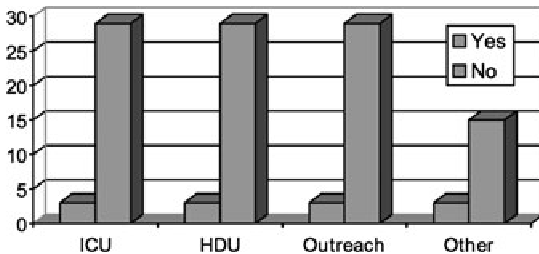
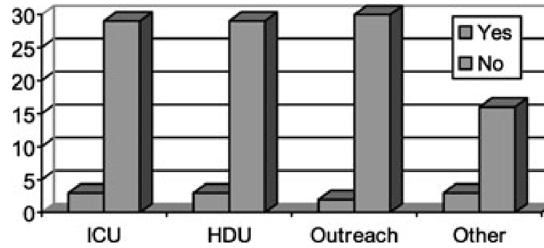
In January 2007, a short questionnaire was sent to the 1960 email addresses on the British Association of Critical Care Nursing database. The email requested the recipient to send on the questionnaire to any known nurse prescribers in critical care; there were 32 responses, and 21 respondents described themselves as prescribing in some way.

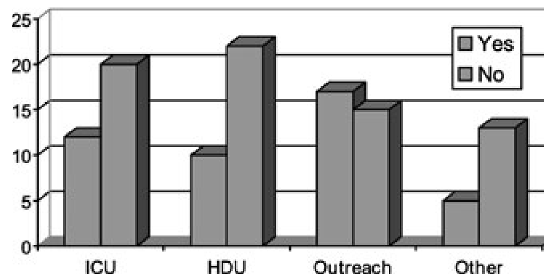
Prescribing medicines as a supplementary prescriber.



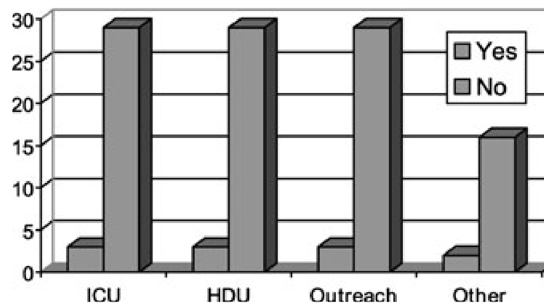
Prescribing medicines an independent prescriber.



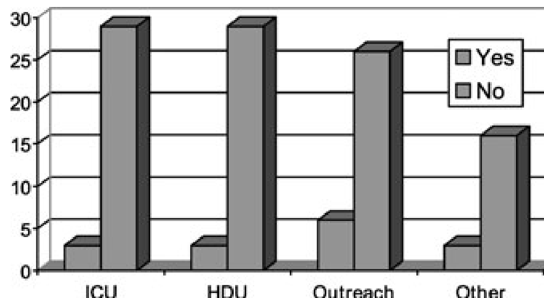
Prescibing using a patient group direction (PGD).



Nurses undertaking a nurse prescribing course to enable them to prescribe.

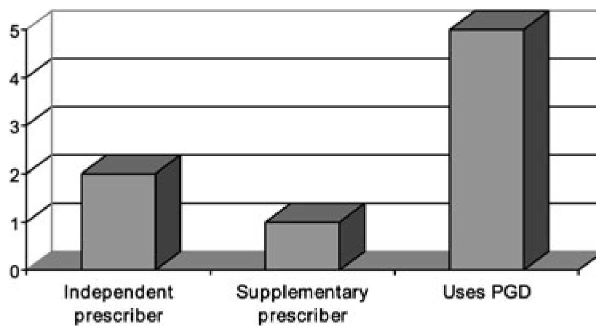


Nurses planning to undertake the nurse prescribing course.



From these 32 responses, 19 people were followed up who had supplied contact email addresses plus 3 other nurses who had not responded but were thought to be non-medical prescribers. Of these, eight people responded and provided the following information on aspects of their prescribing practices.

Prescribing patterns in critical care areas.



Independent prescribing

- Two respondents, both independent prescribers, were consultant nurses.
- Both reported to prescribing medications less frequently than monthly.
- One of these nurses was asked to do the course, and one chose to undertake it.
- Medications prescribed were mainly mucolytics, nebulizers and fluids in acute situations.
- These staff did not want to be undertaking 'proxy prescribing' and sought accountability for their actions.

Supplementary prescribing

This was reported by one nurse in an area of level 2 practice where availability of doctors was limited. The respondent was in the process of becoming an independent prescriber. She had found supplementary prescribing time-consuming because of the paperwork involved.

Use of PGDs

Five nurses reported this; two were currently undertaking an independent prescribing course. Reasons for using PGDs included:

- Easy to use.
- Whole teams such as outreach were able to undertake this.
- Cost-effective.
- Achieves same good results for patients.

The respondents were all working in outreach teams initially. One went to work in a level 2 medical critical care area and is undertaking an independent prescribing course because of lack of medical staff in the clinical area.

Each reported specific PGDs for their teams as well as hospital core ones that were available to use. These included:

- Intravenous fluids in acute situations – generally saline 0.9%.
- Oxygen therapy.
- Paracetamol.
- Nebulizers.
- Lactulose.
- Frusemide.

Reasons for using PGDs were described:

- in acute situations when doctors were not available;
- in certain clinical areas where doctors were not available at all time, unlike level 3 critical care units.

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