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Education

Nurse Prescribing: The Irish Surgical Setting

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ABSTRACT

The introduction of nurse prescribing to the Irish surgical setting is a positive move toward minimizing the fragmentation of care delivery. The social emotional and financial benefits of nurse prescribing have been identified by patients as important and significant in the present uncertain economic climate.

This opportunity for the patient and surgical nurse must be part of a common purpose, in the search for improved patient care delivery.

Key words: Assessment; Accessiblity; Role extension; Prescriptive process; Autonomy; Holistic care

BACKGROUND

Over the last 20 years or so because of technological innovations and improved educational opportunities nursing practice has become more specialized and nurses more highly skilled in response to changing needs of the healthcare consumer. Professional boundaries are constantly being redefined with nursing roles today having an ever increasing responsibility. A key development in Ireland today is the extension of prescribing rights to nurses, which was first raised as part of the health reform in the late 1990s. This health reform is summarized in two documents; a Report of the Commission on Nursing – a Blueprint for the Future [DOHC, 1998] and the Review of Scope of Practice for Nursing and Midwifery [An Bord Altranais (ABA), 2000], which underpin the introduction of nurse prescribing to the Irish setting. During the consultative process employed for both these reports, it emerged through the Commission of Nursing [1999] that 'nurses or midwives might need to administer non-prescribed drugs or medicated dressings in the interest of the patient, but in the absence of medical support'. In addition, The Commission of Nursing [1999] also highlighted that nurses and midwives experienced challenges in their current roles concerning medication management and the impact it had on the delivery of care. Therefore, in 2001, Ireland commenced a review of the role of the nurse and midwife regarding prescribing and administration of medicinal products. The review concluded that involvement of nurses and midwives in medication management would significantly improve patient care delivery [ABA and National Council for Professional Development, 2005]. In particular positive outcomes for patients in relation to satisfaction, greater accessibility for treatment and increased convenience through flexibility of services were identified as well as widening choices for patients [National Council, 2007].

However, concerns exist within the healthcare service internationally, and studies conducted in the United States (US) [Bryant and Clark-Graham, 2002] and Sweden [Wilhelmesson and Foldevi, 2003] suggest that some doctors are reluctant to accept non-medical prescribing, despite evidence that nurse prescribers are able to provide safe, effective prescribing care that is popular with service users. Despite these difficulties, nurse prescribing is extending internationally [While and Biggs, 2004] and looks set to play a pivotal part in modernizing health services in Ireland. Areas that are committed to reaching critical mass of nurse prescribers in their departments are accident and emergency, wound management, diabetic care, care of the elderly, maternity and surgical nursing [Examinations Office UCC, 2007, 2008, 2009].

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CHALLENGES FOR SURGICAL NURSES

Theatre and surgical nursing can be difficult to understand because nursing activities in this area are surrounded by mystery and intrigue for the general public.

Perioperative (pre, intra and postoperative) nursing requires a unique and highly developed set of knowledge skills [Lindwall and von Post, 2008], which include vigilance and adaptation to changing situations as care is delivered to a variety of surgical specialties in every age group – the healthy and gravely ill. Surgical nurses routinely pre-empt emergencies, take action on their changing assessments and resolve problems before they are evident to others, a situation that perfectly positions the perioperative nurse to include nurse prescribing as a natural extension of their role.

As with any new initiative that has the potential to affect clients' health and care delivery, doctors and pharmacists may view prescriptive authority for surgical nurses as a possible erosion of their role, status and authority [Barry, 2007]. Where previously the nurse would have asked medical colleagues to make a decision to prescribe, nurses can now make this decision themselves allowing them to be more autonomous within their practice. This new role challenges the professional boundaries between medical and nursing staff, and shifts the whole working culture from that of a hierarchy to one of multidisciplinary team working [Hay *et al*, 2004; Whitaker, 2006]. An additional advantage nurses have during the prescriptive process is the ability to identify barriers when offering lifestyle advice because of their holistic approach to patient care, which enables them to consider the social context of patients' lives and the impact it may have on the surgical management/experience for each individual patient [Bradley and Campbell, 2005]. Doctors may find it difficult to reach this level of patient understanding when using the medical model approach to care.

Specific training and preparation period for nurse prescribers has been questioned [Barry, 2007] suggesting that it was inadequate. However, what this newspaper article omitted to address is that applicants for the nurse prescribing course have vast experience in their specialized clinical area and are educated to a minimum level 8 (BSc) within the Irish University National Framework of Qualifications. The article further suggested that 'nurse prescribing enthusiasts' may find it difficult to 'balance benefits against risks when prescribing' [Barry, 2007]. In fact the reality of the situation is that the majority of nurses have already been involved in prescribing 'by proxy' [Hughes, 2006] for years because junior doctors regularly rely on the nurse's knowledge and experience to guide them when prescribing for their patients.

Nurse prescribing is still in its infancy in Ireland, but there are challenges for surgical nurse prescribers from insufficient protected time to complete the course; to acquiring experience as a prescriber in clinical practice and the sometimes negative attitudes of the multidisciplinary team to nurses as prescribers [ABA Audit, 2009]. A similar situation was found in Sweden when nurse prescribing was first introduced [Wilhelmsson *et al*, 2001]. However, a later study undertaken in the United Kingdom (UK) in 2004 by Hay, Bradley and Nolan identified the multidisciplinary team as supportive of nurse prescribing but initially confused regarding the nurse's role in prescribing and therefore concerned for how nurse prescribing would be implemented. According to Bradley and Nolan [2007], employer circulated information is important in the development and support for nurse prescribing. To address this situation in the Irish setting a formal evaluation has been commissioned by the Health Service Executive and will be disseminated to the relevant organizations involved in nurse prescribing in August 2009 thereby reiterating the importance of a supportive environment and associated infrastructure for nurturing the new role. It is important to address this lack of information/understanding because the multidisciplinary team needs to be prepared for the impact of nurse prescribing [Bradley and Nolan, 2007] and how it will continue to challenge the traditional healthcare hierarchy in which doctors assumed primary responsibility for all medication-related issues.

Surgical nurses have experienced some anxiety about initially writing prescriptions, which was previously the responsibility of the doctor. This difficulty in commencing prescribing has also been identified by Bradley and Nolan [2007]. However, to put this anxiety in perspective, it may stem form a lack of confidence rather than a lack of knowledge. Anxiety has also presented as uncertainty about diagnosis or fear of an incorrect diagnosis. Again this can be viewed on a continuum, and the multidisciplinary team is essential to provide support for the nurse prescriber, as it does for the junior doctors, until nurse prescribers build their confidence in assessment through experience. However, it has to be acknowledged that the clinical practice of surgical nurses is not totally independent of the medical profession [McGarvey *et al*, 2000]. In reality, there are indisputable nursing actions which are a direct response to medical orders and treatment during anesthesia and surgery. But ultimately it is the patient's recovery process and response to procedures that guides the nurses and medical staff to undertake the most appropriate

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treatment in the surgical setting for which the nurse is best positioned to respond to immediately.

Informal feedback to date regarding Irish nurse prescribing [ABA Audit, 2009] identifies the relationship between the nurse and patient in providing reassurance, continuity of care, information, provision of health promotion and being approachable as the most positive aspects of nurse prescribing. These findings mirror international research [Russell *et al*, 2003]. However, with only one application received from a postanaesthesia care unit nurse where prescribing has been identified as safe and effective [Pritchard and Kendrick, 2001], continuity of care regarding medications in the surgical setting is not fully addressed. Nurse prescribing also brings change, and once the health care team get used to the idea of nurses prescribing, they may be willing to look afresh at structures and procedures in place regarding surgical patients' medication requirements.

BENEFITS FOR SURGICAL NURSES

Research for many years has shown that surgery is associated with increased stress and anxiety and that by reducing preoperative anxiety it is possible to minimize postoperative complications and even reduce recovery time [Boore, 1978; Hataway, 1986; Boeke *et al*, 1991; Kinder *et al*, 2000; Boker *et al*, 2002; Scott, 2004; Salzwedel *et al*, 2008; Haugen *et al*, 2009]. Having a nurse prescriber in the surgical setting could allow nurses to overcome difficulties in the healthcare system that previously delayed patients' access to medicines. This in turn could significantly empower surgical nurses to be more proactive and reactive in responding more quickly to service users, thereby, averting potential crises and leading to increased autonomy and enhanced job satisfaction [Bradley and Nolan, 2007].

Anxiety, for instance has long been established as putting the patient at greater anesthetic and surgical risk [McCleane and Cooper, 1990; Kanto, 1996]. Delayed postoperative recovery resulting from perioperative anxiety is a real risk and can manifest in a number of ways; postoperative complications, reduced wound healing, reduced ability to resist infection, increased post operative analgesia [Kinder *et al*, 2000]. Given the level of perioperative risk that anxiety can create, the introduction of measures to reduce it is warranted.

Pain is a predictable consequence of surgery familiar to most surgical nurses. However, if pain management is inadequate because of a one dimensional assessment, the patient may then experience further unwarranted anxiety resulting in emotional distress and fear, all of which can affect the duration of recovery [Dunwoody *et al*, 2008]. New discoveries in pain management have allowed a greater understanding of the consequences of inadequate analgesia and the need for aggressive pain control in the perioperative period [Dunwoody *et al*, 2008]. As nurses are the primary group of health professionals in the surgical setting instrumental in advocating for the use of medication to manage pain, it is therefore imperative that nurses have an in depth knowledge of medications prescribed, how they work and any potential adverse reactions that may occur. Prescribing enhances nurses' knowledge about medication and increases their confidence to engage in prescribing decisions across the healthcare team [Nolan *et al*, 2004], which helps minimize the fragmentation of care delivery.

In the evaluation of nurse prescribing undertaken by Russell *et al* [2003], social, emotional and financial benefits to the patient were identified as important and have significance in the present uncertain economic climate. It implies that health care today is influenced by larger global changes in which individuals must take control of their own health care needs to ensure a healthy lifestyle.

Research to date also indicates that nurse prescribers can contribute significantly to the improvements and cost savings required in our now challenged health care services. The benefits for nurses themselves were reported as increased nurse autonomy, role satisfaction [Lewis-Evans and Jester, 2004] and career progression [Nolan *et al*, 2004]. Finally, nurse prescribing was seen as improving collaboration between the medical and nursing professions [Nolan *et al*, 2004]. However, there are significant differences between the views of doctors and nurses on the type of information about medicines that should be given to patients by nurse prescribers. Doctors have verbalized that certain aspects of patients needs are best met by nurses. This includes the ability to meet patients' information needs, continuity of care and accessibility [Courtenay and Berry, 2007]. However, benefits identified by Bradley and Nolan [2007] far exceed the generation of prescriptions; '… prescribing enhances the nurses' ability to communicate with patients by increasing their knowledge of medications and their confidence to discuss medications'. These findings are significant for nurses working in surgical areas that engage in continuous assessment and perhaps prompt action to be taken depending on findings.

CONCLUSION

Nurses in the UK have been prescribing for over two decades, and those in the US for over four, yet the

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international literature continues to highlight the barriers affecting prescribing practice. However, there are significant benefits mentioned above and nurse prescribing is a valuable addition to the surgical nurse's skills. It complements nursing and integrates previously diffuse aspects of their nursing role. The opportunity for the patient and surgical nurse must be part of a common world, in the search for improved patient care delivery [Lindwall and von Post, 2008]. To enable this to happen, nurses need to be supported in their development and role expansion to meet the challenges ahead.

Education about nurse prescribing is vital in limiting misunderstanding across the health care service from patients to consultants. Nurse prescribers have a vital role to provide such information/education, as they are partly responsible for defining the scope of their new practice and how they plan to implement it. In light of the present economic climate both at global and national levels, nurse prescribing can contribute significantly to cost effectiveness, time management and improvement required in the health care system to move forward in these difficult economic times.

The current introduction of nurse prescribing into the Irish clinical environment is gradual with evaluation systems firmly in place in order to ensure that nurse prescribing is safe, of high quality and is effective [Latter and Courtenay, 2003; ABA, 2007]. An inherent feature of the nurse prescribing course is the need to comprehend the supportive evidence that underpin medication management decisions thereby, ensuring that nurse prescribers are committed to evidence-based practice, which in turn facilitates best practice to deal with potential ethical conflict, such as pressure to prescribe from patients and the interest of drug companies.

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