Supplementary prescribing: a new way of working for psychiatrists and nurses

AIMS AND METHOD
To describe the implementation of supplementary prescribing and nurse-led care in an acute in-patient unit. The issues of delegation and distribution of responsibility were explicitly addressed. Structures were developed for training and supervision, to ensure improved medicines management in the acute setting.

RESULTS
We present our five-step model of nurse-led in-patient care and our experience of using a clinical management plan for 33 patients.

CLINICAL IMPLICATIONS
Implementation of supplementary prescribing provides a model for new ways of working, requiring engagement of both doctors and nurses, clear delegation and distribution of responsibilities, and well-developed governance structures.

Most psychiatrists are currently involved in an active review of roles and responsibilities as part of the New Ways of Working (Department of Health, 2005) initiative. Key to this is changes within the multidisciplinary team to prioritise consultant workload and the distribution of responsibility and leadership across teams. The General Medical Council has issued guidance on the legal framework for this process of distribution (General Medical Council, 2005) recognising the independent responsibility of nurses, working within their skills and competencies, for patients, without the responsibilities being in any way delegated or supervised by a doctor. The guidance also emphasises the important role of employers in creating a managed, safe environment for this.

Prescribing is no longer a solely medical task, we now have patient group directives, supplementary prescribing and lately independent nurse prescribing (Department of Health, 2006a). Supplementary prescribing is a delegated responsibility, where the overall responsibility for patient management remains with the delegating doctor (General Medical Council, 2006), although the persons delegated to are accountable for their own decisions and actions. The delegating doctor has responsibilities to ensure communication about the patient and the treatment needed, and must ensure that the person delegated to has the necessary qualifications, experience, knowledge and skills.

Supplementary prescribing has the potential to improve patient outcome (National Prescribing Centre, 2005). However, there are acknowledged difficulties in implementation. Organisational barriers and lack of knowledge and confidence have been identified as causes of non-adoption of supplementary prescribing by trained nurse prescribers (Brimblecombe et al, 2005) as has the...
lack of supervisor support. Gray et al (2005) noted ‘the need to explore further the knowledge, skills and confidence of psychiatrists undertaking a nurse prescribing supervision role’.

Little has been written about supplementary prescribing from the psychiatrist’s perspective; implementation and research are nurse-led (Jones, 2006; Nolan et al, 2001). The impact on doctors, in terms of changes in the way of working and the training and supervision of prescribers, is barely mentioned in key documents (Department of Health, 2006b). Supplementary prescribing is repeatedly described as a ‘voluntary partnership between an independent prescribing doctor and a supplementary prescribing nurse’. However, a partnership assumes that both sides work towards a common aim, through an agreed process, on an equal footing. Clearly the prescribing relationship is not equal; the consultant has a depth and breadth of psycho-pharmacological knowledge and therapeutic experience unavailable to even the most experienced supplementary prescriber.

We have developed a model of acute in-patient care which both delegates responsibility for prescribing and distributes responsibility for assessment and care management. We offer some observations based on our experience.

Method

Questions

Acknowledging the literature describing the difficulties of implementation of supplementary prescribing, we started by posing a series of questions, as follows.

Where do we prescribe?

Most community prescribing is carried out by general practitioners on the advice of psychiatrists, the exceptions being crisis situations and long-term depot or clozapine treatments. There is little incentive to take back work from primary care where the infrastructure and governance arrangements are well-established; this is contrary to the Director of Nursing survey (National Prescribing Centre, 2005) which saw the community mental health team as the focus for nurse prescribing. Most specialist prescribing occurs in in-patient settings, an area of medicines management highlighted by the Health Care Commission (2007) as needing urgent improvement.

How could supplementary prescribing improve on the existing arrangements?

Medical time on the wards has reduced, consultants are more community-focused and trainee time is disrupted by shift-working and the need to gain community and psychotherapeutic training. Specialist pharmacists are few in number and hard to recruit, and there is an increasing recognition of the effectiveness of nurse-led care in delivering behavioural change and medicines management (Gray et al, 2004).

How do we obtain the support for systems to change?

Our in-patient services had been through a 2-year re-focusing process with a number of consultants, teams and wards developing new, devolved and more patient-focused ways of working. Consultants can be engaged in a teaching capacity, and a number have gone on to supervise nurses through 72 h of clinical practice as part of their prescribing course.

New way of working in an acute in-patient setting

Skilled expertise rests with the psychiatrist, but not all patients nor all aspects of patient care necessarily require the skills of the psychiatrist. We developed a five-step model where the prescribing responsibility was delegated and the assessment and care management responsibility distributed from the psychiatrist to the nurse consultant.

1. Acute care plan. Acute care is managed by the admitting nurse and psychiatric trainee, for up to 72 h. Priorities are risk management, management of distress, including emergency tranquillisation, and the exclusion of acute medical pathology.

2. Formulation and treatment plan. The consultant and nurse consultant interview the patient and agree the formulation and management plan. Within the plan specific responsibilities, such as medicines management and prescribing, may be delegated by writing a clinical management plan. Responsibilities such as coordinating care and discharge are distributed to the nurse consultant and senior nursing team. Responsibilities for overseeing risk management and Mental Health Act decisions are generally retained by the consultant.

3. Care and treatment. Patients are reviewed by the nurse consultant at least every other day, with formal assessments of mental state and target symptoms, and side-effect monitoring. The care management plan is referred to for prescribing and assessment guidance.

4. Ward rounds and Care Programme Approach reviews. The nurse consultant leads brief weekly ward rounds, to check that all aspects of care are being attended to, and progress is communicated to carers and community staff by written updates. With the relative inward focus of ward rounds, the Care Programme Approach review meetings become the venue for the consultant to provide expert advice and for the community staff to plan discharge options.

5. Consultancy when required. The consultant, although less tied to routine commitments, has to be available for urgent consultation throughout the week, with face-to-face, phone or email contact.

Developing the working relationships

The strength of the relationship lies in the psychiatrist being involved in the supplementary prescribers’ training and ongoing personal development including their supervision. This allows the doctor to be sure of knowing the supplementary prescribers’ strengths and weakness,
building trust and understanding. The primary syllabus for supplementary prescribing is generic to all areas of medicine, and there is an acknowledged gap in nurse education regarding biological psychiatry (Gournay, 2005). Key to the change in working has been the adoption of joint records, written in a shared language, with a shift from the nursing narrative style to the more analytical and hypothesis driven medical style.

Consultant’s role
This has been an active change to standing back from acute patient contact and the clinical processes on the wards, and taking on more supervision and consultation work. This has raised issues of how this new way of working is accounted for in terms of activity, job planning and governance. Patient resistance, and a demand to regularly see the psychiatrist, have not been encountered once the system was up and running.

The central role of the clinical management plan
This is the legally required written plan of treatment which delegates prescribing authority; it is also an exercise in good medicines management. Decision-making is openly shared with the patient, who must consent to the plan. The evidence base is both noted in the plan and used by the supplementary prescriber. Common reference points for us include the British National Formulary, Maudsley Prescribing Guidelines (Taylor et al, 2005) and National Institute for Health and Clinical Excellence guidelines for the treatment of schizophrenia (National Institute for Health and Clinical Excellence, 2002) and mood disorders (National Institute for Health and Clinical Excellence, 2006). A care management plan requires a clear working diagnosis, goals for treatment and a plan of the types of treatments that would be offered with reasons for changing. This helps to prevent situations where patients can be admitted with unclear goals, or the discharge point slips as other issues intrude. Goals also help to define target symptoms for tracking progress, and this brings the whole in-patient nursing team into using the same parameters in their nursing record. The supplementary prescriber and nursing team are also engaged in tracking side-effects, imparting information and influencing behaviour for positive concordance.

Results
We have been working in this fashion for 12 months and, to date, 33 patients have been treated with a care management plan (Table 1), with only one refusal. We started with simple dose titrations, added in adjunctive and side-effect treatments, progressed to treatment crossovers and now write a care management plan that covers a choice of treatments from the relevant British National Formulary groups. In-patient staff are now engaged in formal mental state assessment and systematic medicines management.

Discussion
We have found that by properly acknowledging the issues of delegation and distribution of responsibility, and building systems which help both sides of the supplementary prescribing relationship to feel secure, we have been able to successfully implement this new way of working. This has been accompanied by an extension in practice, so that medical roles such as mental state recording, side-effect detection and coordinating in-patient care can be distributed. This new way of working has to be accompanied by a real change in the psychiatrist’s role to educator and supervisor, with clinical contact confined to only the most complex cases, where delegation of medical work would fall outside the competency of even the most highly trained nurses.

Declaration of interest
G.H. and A.J. have received unrestricted travel and educational grants from Eli Lilly and Janssen.

Table 1. Types of care management plan

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<th>Care management plans, n</th>
<th>Dose titration of named anti-psychotic or mood stabiliser</th>
<th>Switching of named anti-psychotics</th>
<th>Adding hypnotic, anxiolytic or anticholinergic</th>
<th>Adding antidepressant or mood stabiliser</th>
<th>Initiating and dose titration of clozapine</th>
<th>Initiating and dose titration of any anti-psychotic1</th>
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References


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It is widely accepted that severe mental health disorder and substance misuse are strongly associated in community and service user populations. This view is supported by studies in both the USA and the UK. Regier et al (1990) found that 47% of people with schizophrenia and 32% with bipolar disorder misuse drugs or alcohol. Substance misuse was found by Menezes et al (1996) in 36% of psychotic service users, and by Cantwell et al (1999) in 37% of those with first-episode schizophrenia.

Individuals with comorbidity in general are more likely than those with mental health disorder alone to show violent or suicidal behaviour (Swanson et al, 1999), be homeless (Drake et al, 1989), be admitted to hospital and make greater use of emergency services (Bartels et al, 1993). They may be more difficult to treat due to chaotic lifestyles and poor compliance with medication (Cantwell & Harrison, 1996) and may tend to ‘fall between the cracks’ of treatment and care (el-Guebaly, 2004). Several national guidance documents have highlighted the service needs of individuals with ‘severe or enduring mental health problems’ who misuse drugs or alcohol (National Health Service Scotland, 1997; Clinical Standards Board for Scotland, 2001; The Scottish Government, 2003). Currently, because of boundary issues between different services, and busy case-loads, these people can face rejection by services, or be passed between services repeatedly with what has been called ‘the ping pong effect’. Mental health services may see substance misuse as more salient than comorbid mental health problems and pass such individuals on to addiction services. On the other hand, addiction services may feel disconcerted by their coexisting mental disorder, deskilled and unqualified to take them on.

This discontinuity in care has been widely discussed and a consensus is emerging across the UK regarding best practice in caring for individuals with mental health and comorbid substance misuse problems. Two national reports have recommended a ‘mainstream responsibility’ for mental health services (Department of Health, 1999; Appleby et al, 2001). Three main patterns of treatment constitute the sequence of care by mental health services and addiction services (el-Guebaly, 2004). These are: (a) sequential treatment, (b) parallel treatment, and (c) integrated treatment. The last one provides the unified and comprehensive treatment programmes within one service for individuals with concurrent disorders. We believe that...