Editorial

Nurse prescribing: adding value to the consumer experience

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In Australia there is a potential for nurses to provide a wider range of services to patients, including prescribing and management of medications. In particular, patients who are elderly, suffering chronic disease or social deprivation could benefit from increased nursing care. Often, but not always, these people are isolated because of geography and other social factors.

Nurses have always been integral to the quality use of medicines (QUM). Recent government policy statements and a report by the Productivity Commission[1] now provide both an opportunity and a challenge to nurses to extend their scope of practice. This could prevent the unhealthy outcomes that have been associated with less than optimal use of medicines. In accordance with the QUM principles, a range of health professionals working in collaboration could achieve this.[1]

Consistent with international trends, Australian nurse practitioners are now formally authorised to practise in, for example, emergency medicine, mental health, drug and alcohol management, residential aged care, sexual health and neonatal intensive care. Legislative changes to relevant Nurses Acts and Drugs and Poisons Acts across the Australian jurisdictions grant limited prescribing rights to some of these nurse practitioners. The state and territory governments are responsible for regulating the nursing profession so the progress of nurse prescribing varies between jurisdictions. Some states have already appointed nurse prescribers, while others are still piloting their implementation.

A limited number of nurses with relevant qualifications and experience will be able to prescribe drugs from a restricted formulary according to agreed protocols. Some of these nurses will be part of general practices working in a collaborative medical team, whereas others will be working in isolation.

Much of the literature published over the past three decades on the progressive implementation of nurse prescribing comes from the UK, the USA and more recently Australia. A literature review undertaken by the Victorian nurse practitioner taskforce identified the following benefits associated with extending prescribing rights to nurse practitioners:

- improved patient care
- increased convenience for patients
- improved nurse–patient relationships
- improved collaborative practices within the healthcare team
- potentially reduced costs.[2]

An evaluation of nurse prescribing in the UK found that it was generally safe and effective in practice. Nurses, doctors and patients were positive about their experience of nurse prescribing although half of the nurses surveyed said they needed more professional development. Informal peer support was regarded as important in nurse prescribing.[3]

Nurses play a key role in co-ordinating, integrating and educating patients as well as providing clinical expertise. Nurse prescribers in the UK felt that extending prescribing rights has allowed them to make better use of their skills.[3] A major and continuing concern is that having more prescribers will result in polypharmacy and consumer confusion over medications[2],

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Patients are sometimes given a starter pack so that they can try a new medicine before paying for a prescription. While this may be convenient, Marea Patounas and Treasure McGuire report some of the problems patients experience with starter packs.

Starter packs of beta blockers are not often seen. While prescribing patterns may have changed, Maros Elsik and Henry Krum say that there is still a role for these antihypertensive drugs.

The dose of some beta blockers may need to be reduced in patients with reduced kidney function. Randall Faull and Lisa Lee explain some of the principles of prescribing in renal disease.

Patients with diabetes may develop renal disease and they are also at risk of infected foot ulcers. Kerry Bowen tells us how these foot infections should be managed.

particularly if the prescribing nurse does not have access to the complete medical records.[4] Equally, problems may arise if drugs prescribed by a nurse are not integrated into a patient's records. However, it is possible that nurse practitioners might be able to minimise the likelihood of patients experiencing adverse events associated with medicine use.

Many general practitioners seem to have reservations about the safety of nurses assuming responsibility for diagnosis and prescribing medications.[2] There may be concerns if the nurse has to prescribe, dispense and administer a drug. In addition, issues around the legal liability of nurse prescribing remain unresolved. There is also a perceived lack of evidence about the costs attributed to a broader range of health professionals being involved in the management of medications. In a UK survey, doctors could not unequivocally conclude that nurse prescribing had reduced the workload.[3]

There is some difficulty in attributing either positive or negative patient outcomes solely to the nurse practitioner.[5] However, there are major benefits such as improved access to healthcare, better nursing assessment and treatment and a high level of patient acceptance and satisfaction that support the nurse practitioner's role in care. These benefits are likely to be extended if nurse practitioners are able to prescribe.

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Letters

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Echocardiography

Editor, – It was with great interest that I read the 'Diagnostic tests: Echocardiography' article (Aust Prescr 2006;29:134–8), particularly in relation to the ability of this test to differentiate between valvular disease and benign flow murmurs.[1] However, I was surprised that there was no 'Dental note' highlighting the importance of echocardiography in the assessment of patients requiring antibiotic prophylaxis for dental treatment.

A study found that 370 patients out of 20 000 indicated in their medical history that they had a heart murmur or had had rheumatic fever and that they usually received antibiotic prophylaxis for dental treatment.[1] After evaluation of their murmur by electrocardiography and Doppler flow ultrasonography, only 50 had a defect that met current indications for antibiotic prophylaxis for infective endocarditis.[2] Furthermore, the risk of an adverse reaction to the antibiotics and the selection of antibiotic resistant bacterial strains in these patients needs to be considered.

Dental patients reporting an indefinite history of rheumatic fever or cardiac murmur should be referred to their general practitioner, or directly to a cardiologist for diagnosis by echocardiography. This should determine whether or not they require antibiotic prophylaxis for infective endocarditis, in accordance with current guidelines.

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