# Extending prescribing: nurse prescribing and the Crown Review

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***This article discusses the implications of the Crown Review of the Prescribing, Supply and Administration of Medicines on the medical profession and its relationship with other health-care professions. To appreciate the far-reaching implications of the review, it is necessary to reflect on its origins. This article will summarize the history of nurse prescribing, and the current context in which health care is delivered.***

Today, looking back on health care years ago, it seems to have been so straightforward. There were doctors and pharmacists and, after an interval, nurses. The relationships between these groups and their patient can be caricatured as doctors prescribed, pharmacists supplied and nurses administered. To what extent patients adhered to the treatment plan in those days is probably as much of a mystery as it is today.

## REGULATION OF MEDICINES

For the last 30 years the Medicines Act 1968 has ensured that medicines have been carefully regulated throughout the UK, inside and outside the public health system. Few countries, if any, have the tight control over medicines that is the case in the UK. Nevertheless, we know that clinical practice is determined only in part by the law.

The Cumberlege Review of Community Nursing (Department of Health and Social Security, 1986), in the mid-1980s, observed that district nurses were often making the clinical decisions about which dressing or wound care product to use on the patient, but were dependent on the patient's GP prescribing it. Team working often meant that the GP, recognizing the nurse's skills in wound healing compared with his own, and the inefficiency of two clinicians making an assessment of the same wound, would often write a prescription based on the district nurse's recommendation. Undoubtedly, the Cumberlege Team would have witnessed similar circumstances in hospital practice had their review not been limited to community nursing practice.

## THE FIRST CROWN REVIEW

As a direct result of the popular support of the nursing and medical professions for the Cumberlege recommendations on nurse prescribing, the first Crown Review was established in 1989 (HMSO, 1989). Crown recommended that certain nurses holding district nurse or health visitor qualifications should be allowed to prescribe from a limited formulary. There was caution as the Treasury felt that nurse prescribing might be expensive. Indeed it took until 1994 for the legislation to be passed which introduced nurse prescribing to UK health care. The delay was further compounded by the Government's requirements for extensive implementation pilots, involving particular GP practices, then whole districts.

After an extraordinarily thorough evaluation of the impact of nurse prescribing on patients, nurse–doctor relationships and prescribing budgets (Luker et al, 1998), and concerted pressure over years by the Royal College of Nursing and others, the new Labour Government finally agreed to roll out the implementation of nurse prescribing nationwide in April 1998 (Department of Health, 1998a).

That rollout is now underway (Department of Health, 1998b). By April 2001 all 26 000 qualified district nurses and registered health visitors, including practice nurses with either of those qualifications, will be trained to prescribe. Most of them will be prescribing simple medicines from the *Nurse Prescribers' Formulary* (part of the *British National Formulary*; British Medical Association and the Royal Pharmaceutical Society of Great Britain, 1999), although their prescribing is tied into named GP practices, and GPs have the right to veto nurses and health visitors prescribing for patients on their list.

The majority of products are over-the-counter medicines but there are some prescription-only medicines which nurses can prescribe. Primary

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care group budgets are being top-sliced by about 1% a year for nurse prescribing. The evaluation of the Thameside pilot showed that prescribing expenditure on dressings went down by £40 000 in the first 12 months and the number of dressings used went down by 7% (Stuttle, 1999). This was mainly a result of nurses checking what supplies patients already had in their homes and prescribing smaller quantities, matching amounts more precisely with the patient's treatment plan.

Obviously clinical practice has continued to develop while there was the delay in implementing nurse prescribing. The Government set up a review into the prescribing, supply and administration of medicines in the UK in recognition of changing clinical practice.

## THE SECOND CROWN REVIEW

The review team, once again chaired by Professor June Crown, started its work in March 1997. It was charged with reviewing the current situation to identify any changes required, developing a framework for change, and advising on the implications for the law, professional relationships, training and professional regulation. It was to be far-reaching as the review covered the NHS and non-NHS sectors in the UK.

One of the terms of reference related to group protocols. This term was invented to describe the practice by which nurses supplied and administered medicines without a prescription being generated by a doctor. The term has no place in law and there was growing concern in health care, particularly among nurses, pharmacists, and trade unions, that the practice might be unlawful, making the practitioners using them vulnerable to malpractice suits. The review team was charged with clarifying the practice, and advising whether a change in law was required.

The review team comprised twelve members from a variety of backgrounds including four doctors, two nurses and two pharmacists (one hospital, one community). There was also a member of the professions allied to medicine, a patients' organizations representative, a trust chief executive and a health authority non-executive director.

The review team adopted a process which included seeking written evidence from a wide variety of sources. The review team received 759 separate pieces of evidence, each of which was carefully analysed by at least one team member. The review team also established four subgroups which advised the team and helped handle the evidence it received.

## GROUP PROTOCOLS

The first report of the review team was published in April 1998 (Department of Health, 1998c) and its recommendations were accepted in full. It dealt with the subject of group protocols, providing a definition of them, recommending the law in their regard be clarified, and setting a new high standard for protocols. A group protocol was defined as:

> **'a specific written instruction for the supply or administration of named medicines in an identified clinical situation. It is drawn up locally by doctors, pharmacists and other appropriate professionals, and approved by the employer, advised by the relevant professional advisory committees. It applies to groups of patients or other service users who may not be individually identified before presentation for treatment (Department of Health, 1998c).'**

The *Health Service Circular* (Department of Health, 1998d) accompanying the report required immediate action by trusts to review existing protocols in the light of the new definition and standard. The review team intended that the use of group protocols be confined to a tiny proportion of clinical situations in which it was unnecessary for a diagnosis to be made or a prescription generated for an individual. The clearest examples of group protocol situations are:

- Childhood immunization
- Influenza vaccination
- Tetanus toxoid
- Travel vaccination
- Oral contraceptive pill
- Headlice pesticides
- Evacuants used routinely before colonic investigations.

Experience of the implementation of the recommendations over the last year has shown that many group protocols fall outside the Crown definition and standard that would now be applied in law. This may be because the review of an existing protocol has not produced a protocol that meets the standard. Alternatively, the clinicians using the pre-existing protocol have continued to try to squeeze their local practice into Crown — and have ignored the fact that this is not feasible in practice.

The final Crown report was published in April 1999 (Department of Health, 1999), and was consultated on until 7 June 1999 to ensure the widest professional support. The Government gave its commitment to early implementation but it will still take some years for the legislation to come

into force and for the clinical professions to be ready to use it. It contains the farthest reaching recommendations that could have been hoped for.

## WHAT IS PRESCRIBING?

It was interesting for the review team to consider the fact that neither the term 'prescribe' nor 'prescription' is defined in the Medicines Act 1968. It debated whether prescribing is the act of signing one's name on a piece of paper which details the medicines that may be supplied to a named patient, or whether prescribing covers the process of determining a diagnosis, treatment plan that includes a medicinal product, and which is completed by the signing of the authorized signatory's name.

### Independent prescribing

The first of two main recommendations proposes the extension of autonomous (independent) prescribing authority to professions other than medicine and dentistry if individuals in those professional groups meet a number of testing standards. No attempt was made by the review team to describe which sub-groups of professions would be eligible to apply for prescribing authority.

It indicated they would be practising in a narrow clinical field in which their patients needed to be able to access a prescription through them, and that they would have the skills and responsibility for undertaking the clinical assessment leading to diagnosis. It will be necessary for them to have specific post-registration education leading to a recognized qualification, for their names to be visible on their professional register, for them to undergo mandatory continuing professional development in respect of prescribing practice, and participate in clinical audit. Not all these standards are currently mandatory for existing prescribers.

### Dependent prescribing

The review team proposed that a new category of prescriber be developed, that of the 'dependent prescriber'. This practitioner would need the same knowledge base as existing and new independent prescribers, as the risks to the patient if they do not are considerable. This practitioner, however, would be prescribing for patients with a known diagnosis working within clinical guidelines or an individual patient treatment plan.

They are likely to be more numerous and this recommendation should prove particularly useful for the majority of patients with chronic conditions. Their prescribing may involve initial and repeat prescribing and dose adjustment.

## WHO CAN PRESCRIBE?

Applications for determining whether a subgroup of a profession is eligible for prescribing authority will rest with a new body provisionally called the New Prescribers Advisory Committee. This body will determine, on the basis of evidence submitted by professional organizations, whether independent or dependent prescribing authority is appropriate. It is likely that groups such as tissue viability specialist nurses, sports injury physiotherapists and podiatrists may be among the first groups to put themselves forward to gain independent prescribing authority.

While the review team has not specified whether a limited formulary approach should be taken it is possible that this will apply to new independent prescribing. Alternatively each group could practise with the discretion exercised by dentists, prescribing only drugs relevant to their practice. The numbers will inevitably be severely restricted by the limited need for non-doctors to engage in diagnostics. Most nurses work with patients with a known diagnosis. Similarly pharmacists for whom the Crown Report holds great potential overall currently have negligible ambitions to diagnose and prescribe. They are particularly keen to be more involved in repeat prescribing and could take on prescribing related to drugs that require close monitoring and frequent dose adjustment such as warfarin or lithium therapies.

A minority of clinicians, usually specialist nurses working closely with medical colleagues in the hospital sector, have railed against the Crown definition of group protocols, because it has made them realize that they have been supplying or administering a drug that has not been prescribed by a doctor for that particular patient. Many teams have even called their practice 'prescribing under protocol' or 'protocolized prescribing'. Some drugs and therapeutics committees have approved these protocols, and some trust boards or executive directors have claimed they have 'indemnified' the practitioners from the risk of prosecution by a patient who claims harm arising from the practice.

## CONCLUSIONS

Some nurses, and other clinicians, have inadequate knowledge of the Medicines Act 1968. This may lead them to over-estimate their own competence. It may also cause them to underestimate the flexibility already available under the Act in the section that deals with the supply of medicines under the directions of a doctor which will allow for much of the dose altering and supply of 'homely remedies' in inpatient settings that clinical teams need.

Nevertheless, there are a wide variety of clinical scenarios in which patients receive medicines currently that remain outside of the legal provisions. These include accident and emergency departments, minor injuries' clinics, outpatient departments, day care, residential care and wards as well as in primary care settings. Every drugs and therapeutics committee and each clinical team will need to urgently review local practice informed by Crown. **HM**


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## KEY POINTS

- To appreciate the far-reaching implications of the recently published Crown report, it is necessary to reflect on its origins in nurse prescribing.
- The first Crown Review (1989) had recommended that certain nurses holding district nurse or health visitor qualifications should be allowed to prescribe from a limited formulary.
- The national roll out of nurse prescribing began in 1998 after an evaluation of the impact of nurse prescribing on patients, nurse–doctor relationships and prescribing budgets, and concerted pressure over years by the nursing profession.
- By April 2001 all 26 000 qualified district nurses and registered health visitors, including practice nurses with either of those qualifications, will be prescribing simple medicines from the Nurse Prescribers' Formulary.
- The second Crown Review started its work in March 1997 charged with reviewing current practice in UK health care to advise on the need for change in prescribing, supply and administration of medicines arrangements, and develop a framework for recommended changes to law, professional relationships, training and professional regulation.
- The first report of the review team (April 1998) dealt with 'group protocols'. It defined them, recommended the law in their regard be clarified, and set a new high standard for them.
- The final report (March 1999) recommended the extension of prescribing in two ways: independent prescribing and dependent prescribing.
- It also recommended the establishment of a new body provisionally called the New Prescribers Advisory Committee, changes in postregistration education and training, registering prescribing authority, and changes to repeat dispensing and the administration of medicines.