Why bother to prescribe in women's health physiotherapy?

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1. History of non-medical prescribing.
2. Types of non-medical prescribing.
3. Training to become a supplementary prescriber.
4. The role of Non Medical Prescribing in Women's Health Physiotherapy.
5. Patient perspective.
6. Should we bother?

WHY BOTHER ?

- Patients needs at the centre of the NHS.
- Aim is to provide prompt access to high quality care, within safe systems.
- Treatment is personal to individuals needs, providing choice and improving access.
- Achieved by healthcare professionals being more flexible and the development of their roles.

History of Non-Medical Prescribing

- Nurse prescribing been successfully established in USA since 1965.

- In the UK – The Cumberledge Report (1986) and the Crown Report (1989) – first recommended that community nurses able to prescribe – In took 17 years for training to be establish nationally.

Non-Medical Prescribing

- The NHS Plan (2000) – 'empowering appropriately qualified nurses and therapists to undertake a wider range of clinical tasks including … to prescribe drugs'.
- Amendments to the prescription only Medicines order and NHS regulations 2003 & 2005 – enabled supplementary prescribing for physiotherapists in 2005.
- 2006 Nurses & Pharmacists – independent prescribers.

IP – Independent / SP - Supplementary

1998	District nurse / health visitor formulary.	IP
2002	Nurse: extended formulary	IP
2003	Nurses and pharmacists	SP
2003-5	Nurses: extensions to formulary	IP
2005	Chiropodists/ podiatrists, optometrists, physiotherapist and radiographers	SP
2006	Pharmacists	IP
2006	Nurses: full formulary including some CDs	IP
2008	Optometrists	IP

Non-medical prescribing:

To prescribe medication by a qualified health professional other than a doctor or dentist.

Prescribing
Independent or Supplementary prescriber.

Prescription written

Written Patient Specific Direction

PATIENT

Patient Group Directions

Exemptions from the Medicines Act

How patients receive their medicines

Patient Specific Direction

- A traditional written instruction.
- Written by either a : doctor, dentist, nurse or pharmacist independent prescriber.
- For medicines to supplied or administered to a NAMED patient e.g. ward chart.

Patient Group Direction

- A written instruction for the supply or administration of a **Licensed** medicine (or medicines) in an identified clinical situation.

- Where the patient may not be individually identified before presenting for treatment.

Patient Group Direction

For

- No- formal training required.
- Can be used by named qualified health professional from 16 professions.
- Can include a flexible dose range.

Against

- Following a set of instructions which does not allow for creative clinical judgement.
- Setting up is time-consuming & bureaucratic.
- Doesn't allow for patient choice.
- Physiotherapist have no pharmacology training.

Allows nurses to prescribe any licenced medicine for any medical condition that a nurse prescriber is competent to treat, including some controlled drugs.

Pharmacist Independent Prescribing

Allows Pharmacists to prescribe any **licensed** medicine for any medical condition that a pharmacist prescriber is competent to treat.

Is a voluntary prescribing partnership between the independent prescriber (doctor or dentist) and a supplementary prescriber, to implement an agreed patient-specific clinical management plan, with the patients agreement.

Supplementary Prescribing

- Can prescribe any medicine for the patient that is referred to in the plan.
- No restrictions to medical conditions.
- Can prescribe controlled drugs and unlicensed medicines as part of the clinical management plan.

Role of Supplementary Prescribing

Appropriate when:

- Working within a team where a doctor is accessible (only to initially set up a CMP).
- For long term conditions.
- For mental health.
- For situations involving controlled drugs.

- The IP are responsible for the diagnosis and setting parameters of the CMP.
- The SP however can set it up.
- Must be kept simple, can refer to current guidelines.
- The patient must be in agreement of the CMP.
- A review date with the IP must be set – maximum 1 year.
- Must have shared notes.

What is in a CMP

- Patient ID
- Allergies
- Existing medication not included in CMP
- Name of IP / SP
- Condition to be treated
- Aim of treatment
- Treatment plan
- Medication as to prescribe – name / preparation / dose / when to ref back to IP
- Review date
- Process for reporting ADR
- Ref / guidelines supporting CMP

Training to become a Supplementary Prescriber

- Over 35 SP HPC approved courses, delivered at 30 different universities (*www.hpc-uk.org*).
- Training is incorporated into nurse and pharmacist independent prescribing courses.
- Structure varies – **but DoH** sets basic requirements of 26 study days (at least 16 of which are taught days) and 12 days of supervised clinical practice.

- Two exams – Theory & Practical.
- Portfolio – 3 pieces of reflective writing (4000 words).
- Competency document – completed under supervision of your mentor.
- Drug calculations.
- Drug formulary / Clinical management plan.

- What can we prescribe?
- Opportunities
- Advantages
- Limitations

What could we prescribe as supplementary prescriber?

- Anything within the BNF that we have the clinical knowledge and competency.

For Example

- Antimuscarinics for overactive bladder.
- Medication for constipation / diarrhoea.

- Conservative treatment first – ideally within the community.
- Joint working with continence nurse.
- Nurse can be a IP and prescribe medication for the OAB after 6 weeks of bladder re-training.
- Does this reduce our involvement?

Opportunities: Consultant lead clinics

- Gynaecology
- Urology
- Rectal

- Pharmacology Knowledge
- Role / Skill development

Pharmacology Knowledge

- NO pharmacology knowledge taught in physiotherapy training.
- Pharmacology knowledge is **vital to** make good prescribing decisions.
- **Pharmacokinetics** – absorption, distribution, metabolism and excretion.
- **Pharmacodynamics** – the effects the drug will have on the body.

- Medication is part of the treatment available for OAB, increased Pharmacology knowledge will improve our decision making process. We have to become accountable for our prescribing decisions.
- As a SP within a consultant led clinic we can review the patient independently and change their medication or alter the dose.

Limitations

- Doctor has to make the clinical diagnosis and decide on the appropriate drugs to be included into the CMP. As physiotherapists this leads to reduce autonomy.
- Time to write a CMP

Limitations: Hospital Drug Formulary

- The hospital formulary is a way of cost saving.
- At Harrogate only 3 Antimuscarinics are on the hospital formulary (immediate release Oxybutynin, Tolterodine and Solifenacin).
- BUT there are eight Antimuscarinics – if one of these is appropriate for the patient we need to write a letter to the GP.

Limitations: Prescriptions

- Is it hospital policy within your hospital not to give the patients a prescription in clinic unless it is for urgent medication?
- You need to have a budget for the prescriptions.

Concordance

Shared decision making

Consultant led clinics

- Reviewed by same health professional – aids compliance
- Reduced appointments

Patients perspective- Evidence

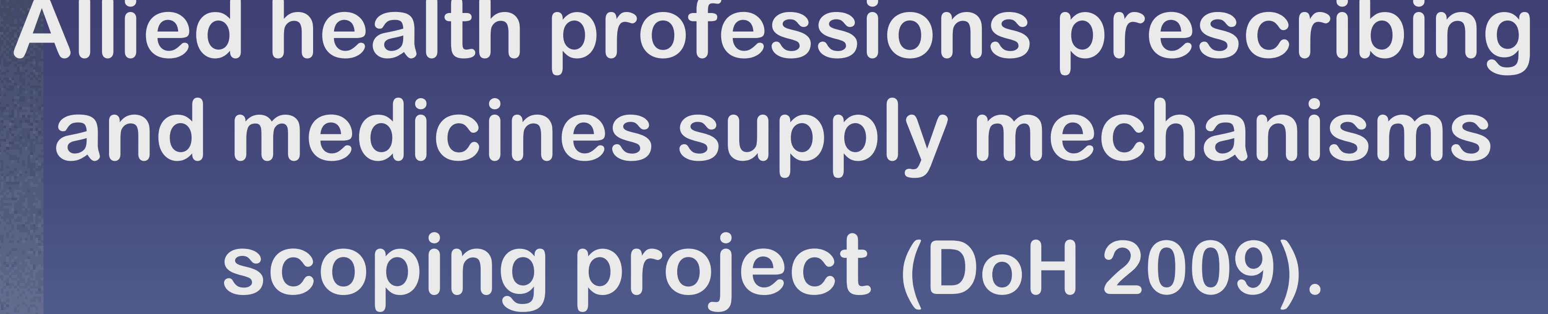
- Very little research in respect to supplementary prescribing (James 2006).
- IP nurse prescribing – small amount of evidence which suggested that nurse prescribing is viewed positively and felt nurses had more time to understand their clinical symptoms (James 2006).

- 147 supplementary prescribers registered with the HPC (out of 42,678) – **0.34%.**

- **SP** – limited use as first consultation needs to be with a doctor.
- **BUT** is patient centre and keeps continuity of care.

Should we bother?

- Is patient group directions enough?
- As part of the multi-disciplinary team should we let other professions take the lead?
- Do we want to take on the responsibility of prescribing?



- On the basis of safety, patient experience, effectiveness and value, there is a strong case in support of progression to physiotherapist becoming Independent prescribers.
- **Recommendation:** Phase 1 – further work should be undertaken to establish – IP by physiotherapist.

- **If legislation comes in to allow IP** – only approx. a 2 day course to convert.
- **Changing NHS** – should we be forward thinking and developing our skills?

Conclusion

- Training to become a SP is costly for the service.
- There has to be identified budget.
- Support of a doctor.
- The physiotherapist has to be happy to take on the extra responsibility.
- Don’t want the nurses to take the led role in continence treatment!

Conclusion

Supplementary prescribing has its limitations

BUT

It dose give physiotherapist the ability use their own clinical skills to **treat patients as individuals** and to alter dosage or change their medication and write the prescription.

THANK YOU

Any Q's