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Non-medical prescribing assessment – An evaluation of a nationally agreed multi method approach

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ABSTRACT

In the United Kingdom, legislation permits nurses and allied health professionals to prescribe for patients within their care. Preparation for this role includes learning, teaching and assessment that is embedded in practice, supervised by a designated medical practitioner (DMP) and evidenced in a reflective learning in practice portfolio.

Aim: The objectives were to explore; (1) which assessment in the practice portfolio was ranked most valuable in terms of achieving safe, effective prescribing practice and, (2) whether a practice based assessment (SDEP) was an acceptable alternative to an Observed Simulated Clinical Examination (OSCE).

Methods: Online surveys were conducted and follow up semi structured telephone interviews were conducted across 5 universities in Scotland with students, DMPs and line managers.

Results: Students ranked the learning log most valuable and DMPs and line managers ranked the SDEP most valuable. Survey and follow up interviews suggested that the portfolio provided the opportunity to develop prescribing skills and knowledge relevant to their specific clinical speciality. There was agreement amongst all participants that clinical assessment in the practice portfolio effectively enable non-medical prescribing students to evidence prescribing competence.

Summary: The novel use of the SDEP and reflective summary offers a viable alternative to an OSCE and was viewed as one of the most valued components of the assessment strategy.

Introduction

Changes in patient and workforce demographics have resulted in substantial developments for UK and international health care policy and service delivery in the last few years. Public health and medical advances mean that patients are living longer with complex and enduring conditions and there is an increased need for care that is holistic, team based and delivered as close to home as possible (Coulter et al., 2013). Such changing needs have resulted in many opportunities for service redesign and development of roles in practice. In terms of professional roles, the opportunity for non-medical staff to become prescribers in their area of clinical expertise, has dramatically changed health care services and continues to do so. For patients and users of services this has the advantage of offering quicker and more efficient access to medications (Courtenay et al., 2011). For professionals who are qualified to do so, it makes better use of their skills, knowledge and expertise (Watterson et al., 2009, Department of Health (DOH), 1999, Health and Care Professions Council (HCPC), 2013). Prescribing has become an integral part of nursing practice globally with countries including the United States of America (USA), Australia, Netherlands, Spain, South Africa, Norway, and Sweden enacting legislation permitting the practice (Kroezen et al., 2012, 2011; Romero-Collado et al., 2014; Lim et al., 2014; Dunn et al., 2010).

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The UK is reported to have one of the most liberal prescribing legislation in the world (Kroezen et al., 2011). There are 2 mechanisms by which nurses and allied health professionals can prescribe in the UK, as an independent or supplementary prescriber. Since 1994 independent prescribing legislation has evolved from nurses prescribing from a limited formulary of medications to optometrists, pharmacists, podiatrists and physiotherapists and nurses prescribing any licensed and unlicensed medication within their professional competence (NICE, 2013). In accordance with amendments to the Misuse of Drugs Act (2015) pharmacy, nurse, podiatry and physiotherapy prescribers have recently been permitted to independently prescribe controlled drugs. Supplementary prescribing is a collaborative agreement between the independent (doctor or dentist) prescriber, supplementary (non-medical) prescriber and the service user. This tripartite agreement is set out in a Clinical Management Plan (CMP) which provides parameters within which the supplementary prescriber can initiate or titrate medications. With such liberal prescribing legislation patient safety is of paramount importance particularly because prescribing errors have been described as the single most preventable cause of patient harm (Williams, 2007). In the UK, medication errors are the third most common cause of patient safety events (Basey et al., 2014) and internationally prescribing errors are identified as an important cause of increased morbidity and mortality (Lewis et al., 2009). An in-depth investigation into the causes of prescribing errors by foundation year (FY) doctors (EQUIP study) reported the prescribing error incidence rate as 8.9% for doctors and 6.9% for nurses (Dornan et al., 2009).

Therefore, to protect patients, prescribing educational programmes necessitate a highly complex process of study, and assessment processes need to mirror such complexities. Compared to Ireland, New Zealand and the USA, UK programmes are shorter, have lower entry requirements and are not necessarily aligned to advanced practice programmes (Kroezen et al., 2011). These lower requirements in the UK do not appear to negatively affect clinical outcomes (Latter et al., 2012) and a recent study suggests that non-medical prescribers are satisfied with the educational preparation they receive (Smith et al., 2014). Although most countries where non-medical prescribing is permitted have guidelines and standards to which educational institutes design their programmes (Kroezen et al., 2011) it has been reported that there is variation in methods of programme delivery and assessment (Lim et al., 2007). This variation may pose a risk to patient safety and reduce movement of staff from region to region. To minimise risk, Scottish universities adopted a national approach to non-medical prescribing assessment. This assessment strategy includes learning in practice, a 'live' practice based assessment and academic written evidence. The assessments include a theory based examination and 6 assessments presented in a learning in practice portfolio of evidence (the portfolio) (Table 1). The portfolio demonstrates clinical prescribing competence relevant to their area of practice and is assessed clinically by students' DMP and academically assessed by the University.

An assessment not widely used outside Scotland is a live practice based assessment, the systematic and detailed examination in practice (SDEP). Practice based scenarios have been reported in the non-medical prescribing literature (Forward and Hayward, 2005) however a recent systematic review of 47 articles (Kamarudin et al., 2013) noted none of the non-medical prescribing studies assessed competence in 'live' prescribing scenarios; instead, they assessed practice in a simulated environment. This assessment method was introduced to non-medical prescribing programmes in Scotland in 2007, takes place in practice with a service user and is assessed by the DMP. A written account of this examination is presented in the portfolio as part of the academic assessment. With professional re-approval scheduled for 2012 and no formal evaluation of the SDEP it was felt timeous to explore the value of this and other aspects of the assessment strategy contained within the portfolio. Therefore this study explored the non-medical prescribing portfolio assessment strategy in Scotland from the perspective of students, DMPs and line managers. It was part of a wider study, funded by the Scottish Government which explored key stakeholders views of the learning in practice experience and portfolio assessment.

Background

The portfolio and learning in practice

Learning in practice is integral to all aspects of nurse, allied health professional, pharmacy, and medical education and based

Table 1
Multi method approach to assessment.