



# Independent extended and supplementary nurse prescribing practice in the UK: A national questionnaire survey

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## Abstract

*Background:* Nurses are able to prescribe independently from a list of nearly 250 prescription only medicines for a range of over 100 medical conditions or, from the whole British National Formulary as a supplementary prescriber. There is some evidence available on the prescribing practices of district nurses and health visitors and early independent extended prescribers. Little or no attention has focussed on supplementary nurse prescribing.

*Objective:* To provide an overview of the prescribing practices of independent extended/supplementary nurse prescribers and the factors that facilitate or inhibit prescribing.

*Design of study:* National questionnaire survey.

*Setting:* United Kingdom.

*Participants and method:* A convenience sample of 868 qualified independent extended/supplementary nurse prescribers self-completed a written questionnaire.

*Results:* A total of 756 (87%) used independent extended prescribing; 304 (35%) used supplementary prescribing to treat a range of chronic conditions (including asthma, diabetes and hypertension); 710 (82%) nurses worked in primary care. Nurses in general practice reported the largest number of reasons preventing prescribing. Reasons included the inability to computer generate prescriptions and to implement the Clinical Management Plan. Nurses in primary care reported more continuing professional development needs. These needs included update on prescribing policy and the treatment management of conditions. A total of 277 (32%) nurses were unable to access continuing professional development.

*Conclusion:* Independent extended/supplementary nurse prescribers work predominantly in primary care and do prescribe medicines. These nurses are highly qualified and have many years clinical experience. Supplementary prescribing is used by a minority of nurses. Implementing the Clinical Management Plan is a barrier preventing the use of this mode of prescribing. The continuing professional development needs of independent extended/supplementary nurse prescribers are frequently unmet. It will become increasingly important that these needs are met once nurses are able to prescribe the full range of medicines included in the British National Formulary, limited only by their area of competence.

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### What is already known about this topic?

- Factors influencing independent prescribing practice include the size and make-up of the practice population, the role of the nurse, interprofessional relationships, informal peer support, access to continuing professional development and the limited choice of medicines available to nurse prescribers.
- There is evidence of low prescribing rates amongst health visitor and district nurse prescribers. This is in contrast to high prescribing rates reported by some early independent extended prescribers.

### What this paper adds

- Supplementary prescribing is used by nurses to prescribe medicines for a range of conditions but it is used to a much lesser extent than independent extended prescribing. Implementing the Clinical Management Plan is a barrier preventing the use of this mode of prescribing.
- The large majority of nurses who access prescribing programmes have more than 10yr experience as a qualified nurse and academic qualifications at degree level and higher.
- Qualified independent extended/supplementary nurse prescribers working in primary care report more continuing professional development needs than independent extended/supplementary nurse prescribers working in primary and/or secondary care. The continuing professional development needs of independent extended/supplementary prescribers are frequently unmet.
- Nurses in general practice report the largest number of reasons preventing prescribing.

## 1. Introduction

During the past decade, the role that nurses play in the management of medicines has undergone a major transformation, particularly in the United Kingdom (UK). Since initial legislation permitting nurses to prescribe a restricted range of drugs was passed (Medicinal Products: Prescribing by Nurses Act 1992) nearly 30,000 district nurses (DNs) and health visitors (HVs) have become qualified to prescribe independently from a limited list of medicines, appliances and dressings, included in the Nurse Prescribers' Formulary (NPF).

The prescribing powers of nurses has expanded yet further following the introduction of independent extended prescribing in 2002 (Department of Health, 2001) and supplementary prescribing in 2003 (DoH, 2002a). Any appropriately qualified first level registered

nurse is now able to prescribe medicines. Qualified independent extended prescribers are able to assess, diagnose and prescribe independently from a list of nearly 250 prescription only medicines (POMs), general sales list (GSL) and pharmacy (P) medicines for a range of over 100 medical conditions described in the Nurse Prescribers Extended Formulary (NPEF). This formulary is to be expanded in Spring 2006 to include the full range of licensed medicines in the British National Formulary (BNF) except for controlled drugs (CDs) (Department of Health, 2005). Supplementary prescribing, by contrast, follows an initial assessment and diagnosis of a patients condition by a doctor, and the development of a Clinical Management Plan (CMP). The CMP (agreed by the nurse, doctor and patient) includes a list of medicines from which the supplementary prescriber is able to prescribe. These medicines must be within the supplementary prescribers area of competence. Supplementary prescribing is best suited to patients with long-term or chronic conditions and nurses using this mode of prescribing are able to prescribe from the full range of medicines in the BNF (including CDs and unlicensed medicines). The intention is to roll out prescribing so that 10,000 nurses throughout the UK become qualified to prescribe independently (DoH, 2002b). There are currently over 8000 nurses qualified to prescribe as both independent extended and supplementary prescribers (NMC, 2006).

Nurses in a number of other countries have the authority to prescribe medicines. These countries include Canada, New Zealand, Sweden, Australia and the United States of America (USA) (Buchan and Calman, 2004). Although there is very little information or research evidence on its effectiveness, it is apparent that this authority has come about for a number of reasons (DoH, 1999; Cornwall and Chiverton, 1997; David and Brown, 1995). In Sweden, prescribing was introduced for nurses in 1994. The introduction of this role for Swedish nurses was to enable patients living in remote areas, access to medicines, and also to reduce the workload of doctors. In Canada and several states in Australia, support for nurse prescribing has been primarily in rural areas where there is a shortage of doctors, and nurses work independently. By contrast, in the USA, nurse prescribing has followed the development of the Advanced Practice Registered Nurse (APRN). The role of this nurse has developed over a 30yr period. These nurses have advanced knowledge and skills and are the only nurses able to prescribe in the States. Nurses across 50 States now have prescriptive authority. Although this authority varies with regards to requirements, standards and practices (Buchan and Calman, 2004), there is evidence to suggest that the care provided by APRNs is well received by patients (Brooten et al., 2002). It is also evident that this care is safe and effective, has consistently improved patient outcomes and reduced the cost of health care (Brooten et al., 2002).

Although prescribing training is available to nurses in Botswana and South Africa, there is an absence of literature with regards to its implementation or evaluation. That which is available reports of planned changes (Meyer et al., 2001).

Given that nurse prescribing is set to grow in the UK, it is important to evaluate the early experiences of this process, and identify key issues. Little attention has focused upon the prescribing patterns of independently extended prescribers and there is no evidence of the extent to which nurses use supplementary prescribing.

## 2. Background

To date, a relatively small number of empirical studies have been conducted to evaluate nurse prescribing. Following a review of the literature, Latter and Courtenay (2004) concluded that the impact and effectiveness of nurse prescribing has largely been a positive development. However, the authors noted that the majority of the studies to date, have largely been confined to the prescribing practices of DNs and HVs. Luker et al. (1997, 1998), for example, in a national evaluation of the first eight DN/HV prescribing pilot sites, interviewed 49 nurses on four separate occasions. A number of benefits were reported including time saving, convenience and increased autonomy. However, the size and make up of the practice population (age, illness and financial status being strong influences) and nurses' role were factors that affected the rate at which nurses prescribed, i.e. DNs were found to prescribe more frequently than HVs.

Similar findings with regards to the rate at which nurses prescribe medicines are reported by Rodden (2001), Otway (2001) and While and Biggs (2004). Rodden (2001) used a questionnaire survey to explore the changes in HVs and DNs prescribers perceived autonomy and independence. Questionnaires were completed by 90 out of 127 prescribing nurses in one National Health Service Trust. More than three quarters of the respondents reported that their autonomy had increased since becoming a nurse prescriber and over 60% felt they had become less dependant on the general practitioner (GP). However, it was evident that the majority of prescribing was undertaken by DNs, HVs prescribing to a much lesser extent. Similarly, Otway (2001), in a survey of over 200 HVs/DNs prescribers, and While and Biggs (2004), who surveyed over 90 HV/DN prescribers across three Trusts, reported that DN prescribed significantly more frequently than HV. Additionally, While and Biggs (2004) reported that the majority of DNs in their sample prescribed less than three times a week. This finding supports earlier work by Luker and McHugh (2002) who reported that approximately a quarter of the 164 DN/HV prescribers they surveyed were not prescribing medicines.

Two studies (Larsen, 2004; Latter et al., 2005) have examined the prescribing patterns of independent extended nurse prescribers. In line with the low prescribing rates of DN/HV prescribers, Larsen (2004) in a survey of 307 nurse managers (working in accident and emergency departments, minor injury units and walk-in-centres) reports that only 27 out of 55 nurses who had undergone prescribing training were prescribing medicines. In contrast, Latter et al. (2005) examining the prescribing patterns of independent extended nurse prescribers, reported that over 90% of the 246 independent extended nurse prescribers surveyed used extended prescribing.

Inter-professional relationships, team working and support in practice are other factors which have been identified as having an influence on prescribing practice. Humphries and Green (2000), in an attempt to identify the infrastructure necessary to support nurse prescribing, undertook 12 focus group discussions using a convenience sample of 146 students (DNs and HVs) on a nurse prescribing programme. Ten key areas were identified as those necessary to support prescribing by nurses and included: protocols; keeping updated; peer support; patient records; project management/managerial support; clinical supervision; awareness of GP and other colleagues; contact with pharmaceutical representatives; safety of prescription pads; mechanisms for patients without a GP. Although nurses in this study were still training to be prescribers, and so views may have changed upon gaining prescribing experience, some of these findings were later confirmed in the work by Otway (2002). Otway's (2002) identified informal peer support, gained through working in teams, as a major source of support. By contrast, working in isolation impacted on confidence and had a negative influence on prescribing (Otway 2002). As in Humphries and Green's (2000) work, awareness by GPs of nurses prescribing role was another factor that influenced prescribing practice.

More recently Hay et al. (2004) provides further evidence confirming the importance of good interprofessional relationships. These researchers used focus group interviews with a range of 46 healthcare professionals to elicit views on supplementary prescribing. In order to use the prescribing role to its full extent, respondents considered support from team members as vital. This finding is endorsed by Pleasance and Brownsell (2004) who used action research to examine relationship between community pharmacists and extended nurse prescribers. Tracking 30 prescriptions issued to patients at a walk-in-centre, it was identified that ten were challenged by ten individual pharmacists. Prescriptions were not challenged on therapeutic or pharmacological issues but rather a failure to understand the role of the extended nurse prescriber.

One consistent finding related to independent prescribing that has clearly influenced prescribing rates is

the limited choice of medicines available to nurse prescribers (Latter et al., 2005; Larsen, 2004; While and Biggs, 2004; Lewis-Evans and Jester, 2004; Otway, 2002; Luker et al., 1997, 1998), nurses claiming that they are unable to prescribe treatments that they consider essential to their nursing practice.

The main themes emerging from the literature indicate that nurses are prescribing medicines independently. Factors that effect prescribing rate include the size and makeup of the population that the practice served, job title, inter-professional relationships, teamwork, support in practice and the restricted formulary. However, much of this research focuses on independent prescribing (and mainly by DNs and HVs) and little is known about the prescribing practices of supplementary nurse prescribers.

### 3. Study

#### 3.1. Aim

To provide a national overview of the prescribing practices of independent extended/supplementary nurse prescribers and the factors that facilitate or inhibit prescribing.

#### 3.2. Methodology

A survey design was used, in which participants were asked to self-complete a postal questionnaire. All questions were 'closed' in nature. Respondents were asked to tick a box to indicate their responses. Quantitative data was generated from this study.

#### 3.3. Questionnaire

A questionnaire booklet was developed for the purpose of this study. Its structure and format was based on previous work involving independent extended nurse prescribing (Latter et al., 2005). In order to pilot the questionnaire, 15 qualified independent extended/supplementary nurse prescribers were asked to complete it. After doing so, they were asked if they found it easy to complete and whether they had difficulty understanding what was required of them at any point. Some minor refinements and amendments were made. However, it was clear from the completed questionnaires that the format and content of the questions were appropriate.

The first page of the booklet contained simple instructions with regards to how to complete the questions. The first section of the questionnaire collected some general demographic information. Participants were asked for their job title, if they worked full time or part time, whether they worked in primary and/or secondary care, their age, their highest academic

qualification, the number of years post registration experience they had acquired prior to undertaking the prescribing programme and whether they felt confident in their prescribing practice. Tick boxes were supplied to indicate responses. Participants were then asked if they had ever prescribed as an extended prescriber and/or as a supplementary prescriber, and to indicate the three conditions for which they had prescribed most frequently using supplementary prescribing. They were also asked to indicate from a list, any factors which had prevented them from prescribing. Respondents were asked to tick all that applied. The final three questions surrounded continuing professional development. Respondents were asked to indicate if they had undertaken any continuing professional development (CPD) since qualifying as a prescriber, to identify from a list of areas where they had any CPD needs and, finally, whether they had access to CPD.

#### 3.4. Participants

The participants were 868 qualified independent extended/supplementary nurse located throughout the UK and registered on the database of a medicines reference guide for nurses (Mims for Nurses, 2005). All those nurses registered on the database, who had indicated on their registration form, that they consented to carefully selected third parties (selected by the publishers of the reference guide) to make contact with them by post, were sent a copy of the questionnaire.

#### 3.5. Data collection

A convenience sample of 1187 qualified independent extended/supplementary nurse prescribers were included in the sample, i.e. over 25% of the total population of nurses registered with the NMC as qualified independent extended/supplementary nurse prescribers at this time. Each participant was sent a letter outlining the purpose of the study and what would be required of them. They were also sent an information sheet and a copy of the questionnaire. The information sheet included a brief description of the aims of the study and what participants would be required to do. It informed participants that the study was completely voluntary and that they could withdraw at any point if they wished to do so. Participants were reassured that responses were strictly confidential, that information collected from the questionnaire would be made anonymous and no identifying information would emanate from the research. After one follow up reminder questionnaire, 868 (73%) completed questionnaires were returned. Data collection took place in January and February 2005.

### 3.6. Ethical approval

Approval for the study was granted by the University of Reading Ethics Committee.

### 3.7. Statistical analysis

SPSS and Splus were used for data entry and analysis. Descriptive statistics were used to describe the demographic nature of the sample. Poisson regression was used to assess the effect of the explanatory variables (i.e. job title, years of post-registration experience, and working in primary and/or secondary care) on the number of factors preventing prescribing and the number of CPD needs. Poisson regression is a form of log-linear analysis common with 'count' (or event) analysis where assumptions of a normally distributed dependant variable do not apply (Gardner, 1995). Specifically the Poisson distribution is skewed and non-negative. As the mean increases, so does variance. Poisson regression adjusts for skewness and in a simple model involving counts as predictors (e.g. number of factors preventing prescribing) and various nominal variables as predictors, (e.g. job title and work place) data are weighted by the count variable. Statistically significant associations determined by the regression analysis were summarised using mean, standard error of the mean and their 95% confidence intervals.

## 4. Results

### 4.1. Job title

Respondents were asked to indicate their job title. A total of 437 (50.4%) worked in general practice (practice nurses, nurse practitioners), 256 (29.5%) as specialist nurses (clinical nurse specialists, specialist nurse practitioner, nurse clinician), 93 (10.7%) as senior nurses (nurse consultants, senior nurses, charge nurses, sisters, managers) and 82 (9.4%) worked as community nurses (HVs, DNs, children's community nurse specialist).

### 4.2. Part time/full time

The majority of respondents worked full time (580 or 66.8%), however 288 (33.2%) worked part time.

### 4.3. Primary/and or secondary care

A total of 710 (82%) nurses worked in primary care, 88 (10%) were based in secondary care and 67(7.7%) worked across primary and secondary care.

### 4.4. Age

One (0.1%) of our sample was under 25, 48 (5%) were aged between 26 and 35, 372 (42.8%) between 36 and 45, 370 (42.6%) between 46 and 55, 70 (8%) between 56 and 65.

### 4.5. Academic qualification

Respondents were asked to indicate their highest academic qualification. A total of 38 (4.4%) indicated that this was at certificate level, 176 (20.3%) indicated that this was at diploma level, 481 (55.4%) indicated that this was at degree level, 161(18.5%) indicated masters level and 4 (0.5%) Ph.D. level.

### 4.6. Years post-registration nursing experience

Participants were asked how many years post registration experience they had prior to undertaking the prescribing programme. Two (0.2%) indicated that this was less than 3 yr. Nine (1%) indicated that this was between 3 and 5 yr; 42 (4.8%) reported that this was 6–10 yr and 760 (87.6%) had more than 10 yr post registration experience.

### 4.7. Confident in prescribing practice

A total of 776 (89%) of the sample reported that they felt confident in their prescribing practice.

### 4.8. Prescribed as an extended prescriber

A total of 756 (87%) participants reported that they had prescribed as an extended nurse prescriber since qualifying to prescribe.

### 4.9. Prescribed as a supplementary prescriber

A total of 304 (35%) used supplementary prescribing to treat a range of chronic conditions. Asthma, diabetes and hypertension were the three conditions for which respondents had used this mode of prescribing most frequently.

### 4.10. Factors preventing prescribing

The factors preventing prescribing by job title are presented in Table 1. In total there were 1107 responses. Poisson regression revealed that there was a difference between job title and the number of factors preventing prescribing. Compared to other areas of practice, nurses working in general practice reported the largest number of factors preventing prescribing. The mean number of factors for each job title is presented in Table 2.

Table 1  
Factors preventing prescribing by job title

	General practice (615 responses)	Specialist nurse (314 responses)	Senior nurses (113 responses)	Community (65 responses)	Total responses (1107 responses)
Inadequate formulary	146 23.7%	77 24.5%	27 23.9%	17 26.2%	267 24.1%
Implementing CMP	131 21.3%	57 18.2%	17 15.0%	10 15.4%	215 19.4%
Lack of prescription pad	108 17.6%	56 17.8%	21 18.6%	16 24.6%	201 18.2%
Unable to computer generate prescriptions	128 20.8%	41 13.1%	13 11.5%	7 10.8%	189 17%
Lack of confidence	58 9.4%	37 11.8%	13 11.5%	9 13.8%	117 10.6%
Other	32 5.2%	29 9.2%	11 9.7%	3 4.6%	75 6.7%
Absence of prescribing budget	4 0.7%	8 2.5%	8 7.1%	2 3.1%	22 2%
Objection by medical staff	8 1.3%	9 2.9%	3 2.7%	1 1.5%	21 2%
Total (%)	100	100	100	100	100%

Table 2  
Effect of job title on the number of reasons preventing prescribing

Job title	Mean	Std. error mean	95% Confidence interval
General practice	2.85	0.12	2.61–3.09
Specialist nurse	2.41	0.18	2.07–2.76
Senior nurses	2.20	0.27	1.68–2.73
Community	1.59	0.20	1.19–1.98

#### 4.11. CPD since qualifying

A total of 505 (58%) members of our sample reported that they had undertaken CPD since qualifying to prescribe.

#### 4.12. CPD needs/access to CPD

The CPD needs of nurses working in primary and/or secondary care are presented in Table 3. In total there were 1920 responses. Poisson regression revealed that overall there was a difference between primary and/or secondary care in the number of CPD needs (see Table 4). This analysis identified that nurses working in primary care reported a greater number of

CPD needs. A total of 277 (32%) nurses were unable to access CPD.

## 5. Discussion

Before summarising the key findings and drawing conclusions, two potential limitations of the methodology must be taken into account. Firstly, the sample included all the qualified independent extended/supplementary nurse prescribers registered on the medical reference guide. It was not a random sample. A second potential limitation is that the length of time participants had been prescribing was not taken into account. This may have affected responses. This is unlike previous work (Latter et al., 2005) where nurses included

Table 3  
Number of CPD needs by nurses working in primary and/or secondary care

	Primary care (1635 responses)	Secondary care (148 responses)	Primary and secondary care (137 responses)	Total responses (1920)
Update on prescribing policy	398 24.3%	54 36.6%	37 27%	489 25.5%
Treatment management of conditions	331 20.2%	23 15.5%	23 16.8%	377 19.6%
Pharmacology	283 17.3%	32 21.6%	30 21.9%	345 18%
Conditions for which prescribed	288 17.6%	18 12.1%	21 15.3%	327 17%
Assessment and diagnostic skills	287 17.6%	14 9.5%	19 13.9%	320 16.7%
Other	48 3%	7 4.7%	7 5.1%	62 3.2%
Total (%)	100	100	100	100

Table 4  
Effect of practice setting on the mean number of CPD needs

Practice setting	Mean	Std. error mean	95% Confidence interval
Primary care	2.76	0.06	2.61–2.86
Primary and secondary care	2.54	0.19	2.17–2.9
Secondary care	1.97	0.16	1.66–2.29

in a questionnaire survey had at least 6 months prescribing experience.

Overall our findings are positive and confirm that most of the independent extended/supplementary nurse prescribers in our sample felt confident in their prescribing practice and prescribed medicines. The majority of these nurses are highly experienced, work full-time and are based in primary care. Nearly all respondents prescribed independently from the list of medicines included in the NPEF. However, although supplementary prescribing was used to treat a range of chronic conditions, this mode of prescribing was only used by a third of participants.

These findings are consistent with those reported by Latter et al. (2005), i.e. the majority of independent extended nurse prescribers in this national survey reported they used independent extended prescribing and also that they had an academic qualification at degree level or higher. Our findings are also consistent with policy literature (Department of Health, 1998; DoH, 2002a), i.e. candidates for independent extended training are those involved in the delivery of one-off episodes of care, such as nurses working in general

practice. Candidates for supplementary prescribing are those involved in the management of chronic, long-term conditions such as specialist nurses running nurse-led clinics. However, the academic qualifications of nurses in our sample, and the number of years nursing experience, are far beyond training guidance laid down by the Nursing and Midwifery Council (NMC), (NMC, 2001) for candidates for the prescribing programme (i.e. candidates must have the ability to study at level 3 and have a minimum of 3 yr post registration nursing experience). This is an important finding. As of Spring 2006, nurses will be able to prescribe from the full range of licensed medicines (apart from CDs) described in the BNF (Department of Health, 2005) (limited only by their area of competence), and there have been some concerns about this development (BMA, 2005). These concerns have focused upon nurses' academic knowledge and clinical experience. Our findings highlight the wealth of clinical experiences nurses have acquired prior to entering the prescribing programme and also that many of these nurses have acquired academic qualifications beyond degree level during this period.

A number of factors prevented participants in our sample from prescribing medicines, and nurses in general practice reported the largest number of factors. The inability to computer generate prescriptions and an inadequate formulary were amongst those reasons most frequently reported.

This finding is consistent with the literature (Latter et al., 2005; Larsen, 2004; While and Biggs, 2004; Lewis-Evans and Jester, 2004; Otway, 2002; Luker et al., 1997, 1998), nurses claiming that they are unable to prescribe treatments that they consider essential to their nursing practice. The expansion of the formulary in 2006 and the recent introduction of software enabling nurses to computer generate prescriptions should overcome these obstacles to prescribing.

Other factors reported by participants as preventing prescribing, involved arrangements that should have been put in place by respondents employers prior to nurses accessing the prescribing programme (e.g. arrangements for prescribing budgets and distribution of prescription pads) and the implementation of CMPs. It is particularly important that the problems surrounding the implementation of CMPs are identified and addressed. As well as supplementary prescribing providing the only mechanism by which nurses are able to prescribe CDs and unlicensed medicines, this mode of prescribing provides a valuable framework within which nurses, prescribing medicines for conditions for which they feel less confident, are able to prescribe in partnership with a doctor. Additionally, many older patients with chronic conditions may have multiple pathologies treated by complex drugs. It is unlikely that all nurses will feel confident to assess, diagnose and prescribe independently for each of these conditions as well as deal with complex polypharmacy issues. Supplementary prescribing provides an ideal framework within which to prescribe in this situation. Problems surrounding the implementation of CMPs therefore require further exploration.

Just over half of our sample had undertaken CPD since qualifying to prescribe. This is in line with findings reported by Latter et al. (2005). Of the independent extended prescribers in this survey 52% reported that they had undertaken CPD since qualifying. A number of areas were identified by nurses in our sample as areas in which they required CPD. Nurses in primary care reported a greater number of CPD needs (although this may be a reflection of the small numbers of respondents in the secondary care and primary and secondary care groups). Of our sample 32% reported that they were unable to access CPD. With the imminent expansion of the NPEF in Spring 2006, the need for CPD by nurse prescribers will increase. If nurses are to prescribe safely and effectively it is important that these needs are addressed. Further research exploring the inability of nurses to access CPD is required.

## 6. Conclusions

Independent extended/supplementary nurse prescribers work predominantly in primary care and do prescribe medicines. Supplementary prescribing is used by a minority of nurses. Barriers to implementing the CMP require further exploration. The large majority of nurses who access prescribing programmes have more than 10 yr experience as a qualified nurse and academic qualifications at degree level and higher. However, once qualified, the CPD needs of these nurses are frequently unmet. This requires further exploration as it is important, if nurse prescribing is to be safe and effective, that these needs are met. This will become increasingly important once nurses are able to prescribe the full range of licensed medicines included in the BNF, limited only by their area of competence.

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