

The Integration of Nurse Prescribing: Case Studies in Primary and Secondary Care.

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ABSTRACT.

THE INTEGRATION OF NURSE PRESCRIBING IN PRIMARY AND SECONDARY CARE.

Nurse independent and supplementary prescribers have legal authority to prescribe all licensed and unlicensed medicines with some minor restriction to prescribing controlled drugs. These prescribing rights are similar to those of doctors. To be effective, the integration of nurse prescribing must be consistent with the legal framework for nurse prescribing and, be acceptable to the nurse, employer, patient and healthcare team. There is little known about how prescribing is integrated in practice but agreements are potentially important to the organisation of professional work and may ultimately affect patient safety.

These case studies set out to investigate how nurse prescribers integrate prescribing in primary and secondary care. Each case, a nurse prescriber, had completed the independent and supplementary prescribing course at one university between September 2004 and January 2007. Of the 26 cases recruited 13 had been qualified to prescribe for between 7 and 13 months, and 13 for 14 and 26 months. Data collected through semi-structured interviews, field notes and attribute data was drawn together in case summaries. Data analysis showed effective integration to be dependent upon professional relationships and prescribing role agreements.

Prescribers outlined three approaches to integrate prescribing. These were; prescribing as the opportunity presents, prescribing for specific conditions and prescribing for individuals. Prescribing as the opportunity presents reflects medical models of prescribing. Condition specific and individual approaches restrict prescribing to specific medical condition(s) or individual

patients. These nurse prescribers preferred to use Independent prescribing. Reflecting this, prescribers showed higher levels of dependence on doctors than previously reported. This was most common in the first year of prescribing. Relationships between nurse prescribers and the team were important. New nurse prescribers raised unexpected issues in some intra-professional relationships. However, it was the inter-professional relationship between nurse and doctor that determined integration. The nurse must believe, trust exists and is reciprocal to integrate prescribing in practice. Where there was an absence of trust or a concern of mistrust the nurse would not integrate prescribing.

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CHAPTER 1: INTRODUCTION.

Case studies in nurse prescribing: the integration of nurse prescribing in primary and secondary care.

1.1: A Curiosity.

As a lecturer, I lead the non-medical prescribing course. This programme of post registration education prepares nurses, pharmacists and allied health professionals (physiotherapists, podiatrists, chiropodists and radiographers) to be independent and supplementary prescribers. My study developed out of informal conversations with nurse prescribers. New nurse prescribers talked about how they were going to integrate prescribing in their area of nursing practice. Partly to the conversations I was struck by the variation about which, they spoke. Some were confident, some cautious and others very unsure of how to begin. I observed how some would talk about prescribing for patients known to them whilst others were happier to prescribe for new patients presenting for example, in minor illness clinics. The prescribers nursing role, the employer or the number of years nursing experience did not easily explain the variation I observed. This led me to conclude that factors individual to the nurse and the clinical environment within which prescribing takes place affect the integration of nurse prescribing in practice.

Understanding the observation, I had made about prescribing integration and investigating why they might occur is important to nurse prescribing and the nursing profession. The prescribing actions of a nurse prescriber are likely to be judged against public and professional expectations of a medical prescriber. The approaches to prescribing integration that nurse prescribers spoke of in their conversations with me did not necessarily

reflect medical systems of prescribing. These conversations suggest that there are a variety of factors which shape how the nurse integrates prescribing in practice and determines if he or she will or will not prescribe for patients. Defining these factors and understanding how these factors shape the integration of prescribing would bring the profession closer to a position where prescribing education and employing organisations can best prepare and support nurse prescribers.

1.2: Why is this Research Important?

The claim by nursing for jurisdiction of prescribing challenges professional boundaries in the division of labour. The successful implementation of prescribing policies is dependent upon the creation and management of a new division of labour between nursing and medicine. Little is known about how nurse prescribing is integrated in practice and yet these agreements are potentially important to the organisation of professional work and may ultimately affect patient safety.

1.3: A question for research.

My research question asks, how effectively is nurse prescribing integrated into primary and secondary care? My focus is nurse prescribing and my aim, to investigate the integration of nurse prescribing in primary and secondary care settings from a nursing perspective. This is a study of nurse prescribing and I do not include pharmacist or allied health professional prescribers. The reason for this decision was that I believe the independent prescribing formulary is influencing the integration of prescribing in practice. Allied health professionals do not have authority to prescribe independently and pharmacists only gained authority in 2006.

In the context of this research, the integration of prescribing involves the activities of combining and acceptance. How colleagues and doctors accept nurse prescribers into the prescribing team. To prescribe for patients there needs to be a new division of labour in the workplace. How nurse prescribers combine prescribing skills and nursing knowledge to prescribe for patients. Findings from this study will contribute to the evaluation and development of prescribing education by description and analysis of integration during the first years of prescribing.

Whilst nurses are the focus of this study, there are areas of discussion in this thesis relating to nurses, pharmacists and AHP prescribers. I use the term 'non medical prescriber(s)' to refer to healthcare professionals with authority to prescribe but are not doctors. I also use the words 'nurse prescriber(s)' this term includes midwives and health visitors who have the same prescribing rights and work to the same legal framework when prescribing as nurses.

1.4: Nurse Prescribing: The background and the history.

1.4.1: a claim for jurisdiction.

The nursing profession began a claim for jurisdiction of prescribing in 1978 when the Royal College of Nursing (RCN) presented a report proposing that nurses should have authority to prescribe dressings and topical treatments, Jones (1999). It was not until 1986 when Julia Cumberledge included nurse prescribing in her report, Neighbourhood Nursing; a focus for care (DHSS 1986) that the claim was considered by the conservative government of the time. The RCN had welcomed the opportunity to work with Cumberledge and to invite discussion about nurse prescribing to a wider audience, Jones and Gough (1997). The report was visionary in its

presentation of nurse prescribing as an opportunity to improve community health services. Whilst the government had given a positive response to the report, Jones (1999 p8), the RCN were aware nurse prescribing would not be possible without support from the British Medical Association (BMA) and the Royal Pharmaceutical Society of Great Britain (RPSGB). In 1988 the RCN presented the BMA and RPSGB with a discussion paper. The intention of this paper was to outline criteria for nurse prescribing. In his book, Jones gives a detailed account of the development of nurse prescribing, but he does not provide details about medical opposition to nurse prescribing (Jones 1999). He simply states; "after much initial opposition and a good deal of negotiation a tacit agreement between nursing, the BMA and the RPSGB was reached" Jones (1999 p 8).

In order to create a legal framework for nurse prescribing the 1968 Medicines Act had to be amended. Allowing parliamentary time for the amendments was not, according to Sims and Gardiner (1999), a priority for government. The amendments were finally made in 1992, fifteen years after Cumberledge had first written in support of nurse prescribing. The conservative government of the late 1990's were concerned about prescribing costs and therefore reluctant to extend prescribing authority (Jones 1999). They did however agree to a pilot project of community practitioner prescribing in 1994 and announced the roll out of prescribing to all District Nurses and Health Visitors in 1998. Over the following eight years the labour government embarked upon a programme of prescribing policy growth. Prescribing polices formed part of a wider range of policy developments from the labour government aimed at increasing the efficiency and cost effectiveness of the NHS through modernisation.

Jones comments, nurse prescribing was "one of the hardest fought battles in nursing" Jones (2004 p266).

In two government reports, Dr June Crown explored the potential benefits of nurse prescribing (DH 1989; DH 1999 a). She was particularly interested to improve the patient experience by extending prescribing rights. Her reports conclude nurse prescribing would enable patients to have faster access to healthcare services DH (1989); DH (1999a). Research by Luker, Austin, Hogg et al. (1998a); Brooks, Otway, Rashid et al. (2001) sought specifically to explore the patient experience of nurse prescribing. Their conclusions show that patients are happy for nurses, who have been properly trained, to prescribe for them. Patient views are explored in more detail in chapter 2, but they are not the focus for these nurse prescribing case studies. Patient views are included in the thesis but are not discussed in depth.

The 2003 introduction of supplementary prescribing allowed the nurse to prescribe all items listed in the British National Formulary (BNF). The change was met with some opposition from medicine. Horton's views are the most frequently cited in the literature Horton (2002). Supplementary prescribing gained acceptance because it uses a prescribing partnership between doctor, nurse and patient. Under supplementary prescribing the doctor has responsibility for the diagnosis and must agree appropriate treatment in a patient specific clinical management plan DH (2005). The extension of prescribing authority for nurses and pharmacists in 2005 was the most strongly opposed by doctors to date. The extension, which came into force in 2006, allowed independent prescribing from the whole BNF with some minor restriction to the prescribing of controlled drugs. Doctors condemned the plans. The BMA were reported to have been taken

by surprise at the announcement, and called for an urgent meeting with the then secretary of State, Patricia Hewitt, Day (2005). Through the media and the medical press, doctors described the plans as “irresponsible and dangerous” BBC (2005 p1) ; Day (2005 p 1159). Lacobucci (2006) cites information obtained under the Freedom of Information Act. Patient groups had responded to the consultation with cautious agreement. The medical profession opposed the plans. His investigation revealed that none of the 16 medical bodies who responded to the consultation had supported the plan.

It is useful to remember that the BMA were initially persuaded to support nurse prescribing based on the context of an RCN discussion paper outlining the criteria for nurse prescribing. The initial forms of limited prescribing identified in the document and presented to the BMA were different to the massive extension of prescribing authority announced in 2005. The reaction of the BMA described in the press at the time, suggests they had the same opportunity to comment on proposals as everyone else but were not included in the decision. According to Day (2005), medical opposition to independent prescribing from the whole BNF is based on the argument that nurses and other non medical prescribers are not trained to diagnose disease. Medical opinion has been heard, but I would argue overruled. In 2009 / 2010 the government are expected to announce the removal of restrictions to the independent prescribing controlled drugs by non medical prescribers. If this goes ahead it will give the non medical independent prescriber identical prescribing rights to those of doctors.

1.4.2: social structures and healthcare services.

An increasing ageing population, the burden of disease, advances in medical technology and rising public expectations found the NHS struggling

to meet healthcare demand. The organisation and delivery of healthcare services are not isolated systems but are shaped by wider social structures. The sociology of health literature suggests these social structures place external pressure on the organisation and delivery of healthcare services (Taylor and Field 2007; Peckham and Meerabeau 2007). The increasing numbers of elderly people in the population presents new challenges to the NHS. The number of people aged 75 and over is set to increase from 4.7 to 8.2 million by 2031, Office for National Statistics (2007). This older age group place a greater demand on healthcare services than younger age groups. Darzi reports, the average over 85 year old to be fourteen times more likely to be admitted to hospital for medical reasons than the average 15-39 year old, DH (2008 P26).

Advancements in medical technology and drug therapies mean that people are living for longer. Increasing length of life does not always equate to healthier lives. The burden of disease on healthcare services increases as greater numbers of people are living longer lives with chronic disease and co-morbidity, Taylor and Field (2007). Pharmacological advances have a role too. Medicines are more effective in the treatment of disease and the control of symptoms. As new drug therapies become more widely available greater numbers of patients are treated or have disease prevented with drug therapies and overall costs to the health service rise (Taylor and Field 2007).

Technological advancements in medicine have also changed the way health services are delivered. Hopkins, Solomon and Abelson (1996) reported over ten years ago that these technological advances were eroding the control health professionals have over their work. They do however have significant benefits for patients, professionals and society as these

advances reduce the length of hospital stays and allow treatments previously requiring admission to be undertaken in hospital outpatient and primary care settings.

1.4.3: expanding nursing roles and the healthcare marketplace.

The conservative government introduced market forces bringing business and management strategies in to coordinate welfare services (Mooney 2006). These policies allowed and encouraged competition between the different components of the NHS through what are called quasi or internal markets. In this market, organisations are split into distinct roles of purchaser or provider. Market mechanisms are used to develop more efficient forms of delivery and offer better value for money from the NHS. According to Mooney (2006) the distinction between purchaser and provider had been central to the NHS reforms of the conservative government. Rather than dismantle these policies the labour government have, since 1997 continued this path of development. Taylor and Field (2007) describe this approach as a 'marketisation' of welfare.

Marketisation is achieved through private investment and by making state controlled services more responsive to market forces. In the health marketplace patients take the role of consumer and demands for reduced waiting times, standardised service and improved access to healthcare have to be met. From 1997 Blair and his government set about modernising the NHS (DH 2000a). The reforms would not be possible without a suitably trained workforce. In the previous year the government published a strategic document 'making a difference' in which nurses were encouraged to make better use of their skills and knowledge and to develop nurse led services DH (1999b). Included in the NHS plan the following year the Chief Nursing Officer outlined 10 key roles for nurses

which reinforce the directive and challenge the boundaries of a traditional division of labour. Nurses were expected to develop nurse led services, to order diagnostic tests and to prescribe (DH 2000a). These policy initiatives have opened opportunities for nurses to expand their roles in primary and secondary care.

In primary care the Quality Outcomes Framework brought into general practice in 2004 (McElduff et al., 2004) encouraged the management, monitoring and prevention of chronic disease to move from secondary to primary care services. Community matrons have been appointed to new roles as case managers for elderly patients with chronic disease and co morbidity. Their role specifically requires prescribing and aims to keep elderly patients out of hospital and in their own homes. Advancements in medicine create increasingly complex genres of medical knowledge leading the medical profession to move to specialised roles. In secondary care nursing services have also moved towards models of specialist practice. Prescribing authority enables the clinical autonomy central to these new nursing roles. Without nurse prescribers a doctor must be present and as Hill (2003) points out doctors are in short supply. These nursing roles aim to preserve limited medical resources for the most seriously ill patients (Hill, 2003) leaving patients presenting with less serious conditions still requiring prescribed medication. Nurses as the largest group of healthcare workers in the NHS would make up the largest group of non-medical prescribers suitably trained to meet this need.

These reorganisations challenge the existing division of labour. Nurse prescribing has moved nursing from a model of clinical diagnosis for nursing care to one of clinical diagnosis for drug therapy. The expectations of nurse prescribers have, as a result moved prescribing in traditional

nursing roles to prescribing in new roles and nurse led services. Prescribing policies offer the nurse the autonomy of prescribing that these roles require. However, in their own right these roles challenge the division of labour and consequently raise questions about the clinical knowledge on which prescribing decisions are made.

1.5: Prescribing policy development.

The quest for Nurse prescribing was at first driven by the profession. Jones (1999) describes how the RCN lobbied, courted and persuaded professions and politicians for support. The state was at first hesitant, requiring a series of pilot prescribing sites before agreeing a national roll out of nurse prescribing in primary care. After a slow start, the state went on to play an important part in the development and definition of prescribing policy. Policy initiatives developed in the late 1990's to increase patient access to services and relieve pressure on front line staff required healthcare organisations to develop new ways of working. Nurse led services in walk in centres and minor injury units are hindered if the nurse is not able to prescribe (Jones 2004). In the context of policy to modernise the NHS demands from the nursing profession to extend prescribing authority were to find a supportive government.

Following the publication of the NHS Plan (DH 2000a) prescribing policies went through a series of rapid developments, which over an eight-year period, opened the opportunity to prescribe to all nurses, pharmacists and some allied health professionals (AHP's).

These extensions to prescribing authority were driven by demands from the nursing, pharmacy and allied health professions. It was however the state which positively received their requests and quickly took action to

amend the necessary primary and secondary legislation. The state took steps to bypass potential medical opposition choosing to include them only in the consultation stage of policy development. In supporting demands from non medical professions the state enabled the NHS modernisation agenda. Without state support it is unlikely non medical prescribers would have secured the extensive prescribing authority that they have. The role of the state is not the focus of this thesis but an understanding of this role will provide a background to understanding the literature, findings and discussion. At points throughout this thesis the reader will require knowledge of these policy developments. Here I present a brief summary to highlight significant points relevant to this study.

Table 1.1 Shows three key developments in nurse prescribing policy; Independent Community Practitioner prescribing, Independent prescribing and Supplementary prescribing. In her second report, Crown outlined a framework of independent and dependent prescribing. The title of 'dependent prescribing' was used only once in the report and is known instead as supplementary prescribing DH (1999). Independent and Supplementary prescribing is the legal framework of non-medical prescribing in England. Between 2003 and 2006 a series of amendments have removed many of the early restrictions placed mostly on independent nurse prescribing but in addition to pharmacist prescribing. I have listed the amendments to prescribing policy in the right hand column of the table. The outcome of prescribing policy development is that since 2006 nurse prescribers have had almost identical prescribing rights to those of doctors.

1.5.1: two types of prescribing.

Throughout the thesis I refer to Independent and Supplementary prescribing (DH 2005; DH 2006). The reader will need to be conversant

with these types and the key difference between them. Understanding the difference between them is important for understanding the analysis and discussion sections of this thesis. Below I outline the working definitions.

The legal framework of nurse prescribing has two types of prescribing, independent and supplementary. The Department of Health provide working definitions of the two (DH 2005: 2006).

Independent Prescribing

“prescribing by a practitioner responsible and accountable for the assessments of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing”.

DH 2006 p2 no 8.

Supplementary Prescribing

“ a voluntary partnership between an independent prescriber (a doctor or dentist) and a supplementary prescriber to implement an agreed patient specific Clinical Management Plan with the patients’ agreement”.

DH 2005 no 8.

The key difference between independent and supplementary prescribing is who takes responsibility for the diagnosis. When prescribing under independent prescribing arrangements the nurse prescriber takes accountability and responsibility for the diagnosis and plan of treatment. Under supplementary prescribing arrangements the responsibility for the diagnosis lies with the doctor.

Table 1.1: Key Developments in Non Medical Prescribing Policy.

Year & Type	Prescriber	Formulary	Amendment 2006 / 2009.
1999 Independent prescribing	Nurses Community Practitioners District Nurse Health Visitor	Restricted formulary; Community Practitioners Formulary	community practitioner restriction lifted and prescribing opened to all nurses as V150 community practitioner prescribing in 2007.
2001 Independent prescribing	All nurses who meet NMC eligibility criteria to enter prescribing courses. (NMC 2006) Pharmacists from 2006.	British National Formulary (BNF) Independent prescribing for nurses list of controlled drugs. Prescribing within and outside the product license.	2001 – 2006 restricted prescribing from Extended and Independent nurse prescribers formulary in the BNF. 2006 restrictions lifted. Can prescribe all licensed medicines listed in the BNF. Nurse prescribers can independently prescribe some controlled drugs from independent prescribers formulary.
2003 Supplementary prescribing	Nurses Pharmacists Allied Health Professionals (AHP's)	British National Formulary. Licensed and unlicensed medicines. Within and outside product license. AHP's cannot prescribe controlled drugs.	No changes

1.6: Summary of introduction.

As part of my job observing and talking to nurse prescribers, I found nurse prescribers were talking about different ways to integrate prescribing into nursing practice. These observations informed the development of a research question. My question takes a nursing perspective to ask, how nurses integrate prescribing into primary and secondary care. In essence, the integration of nurse prescribing is about prescribing being accepted as a nursing role by the prescribing team. Once accepted it is then about combining prescribing with the nursing role and starting to prescribe for patients. To combine and accept prescribing into the workplace a change to the division of labour between doctor and nurse is necessary. In the clinical environment a new division of labour must be negotiated and agreed before prescribing for patients can begin.

This nurse prescribing research, framed in the context of professional boundaries, explores the claim by nursing for jurisdiction of prescribing and the change to the division of labour. The claim for jurisdiction of prescribing for nurses came first from within the profession. The BMA and RPSGB were persuaded to support changes to legislation that would enable nurse prescribing. However, it was not until healthcare policies were introduced to improve the effectiveness and cost effectiveness NHS services that opportunities for non-medical prescribing were realised. The extensions to prescribing policy that followed were opposed by the medical profession and yet were enabled by the state. Prescribing, as a role for nurses, is still in its infancy and these individual factors affect how the nurse starts to use prescribing in practice. Little is known about how nurse prescribing is integrated in practice and yet these agreements are potentially important to the organisation of professional work and may ultimately affect patient safety. My research argument proposes that there are factors, both

personal and in the context of the clinical environment which serve to determine the integration of prescribing in practice.

CHAPTER 2: A Review of the Literature

2: The purpose and process of the review.

This chapter presents a review of the literature in two sections. The first aims to establish the current state of knowledge about how nurse prescribers integrate prescribing in primary and secondary care practice. The second draws on the nursing and professions literature to identify how doctors and nurses view the blurring of professional boundaries. This leads into an exploration of the division of labour with reference to the sociology literature and in particular the work of Abbott (1988).

2.1: Identifying the literature.

A search of the literature was conducted using the following nursing and health databases, Cinahl EBSCO, EMBASE, ISI web of knowledge, British Nursing Index. The search began with the key word 'nurse prescribing'. This identified UK and international nurse prescribing literature and included all types of non-medical prescribing. I narrowed the search by using the key words 'independent prescribing' and 'supplementary prescribing'. These restrictions removed international literature from the search findings because the terms are specific to United Kingdom nurse prescribing. To focus on the research question directly two further searches were undertaken using the key words 'nurse prescribing and integration' and 'nurse prescribing and professional boundaries'. The search results are, shown in Table 2.1. The papers identified were scrutinised to identify research papers from articles and news pieces. In total, the search identified 43 research papers. Several publications reported different aspects from the same study.

Table 2.1: The structure of the literature search.

Key words Data Base	Nurse prescribing	IP	SP	Integration & nurse prescribing	Professional boundaries & nurse prescribing
Cinahl EBSCO	3038	352	149	1	1
British Nursing Index	798	92	117	0	0
EMBASE	382	412	110	2	1
Psyc INFO	134	107	21	1	0
ISI Web of knowledge	99	14	30	0	0
IP - Independent nurse prescribing SP - Supplementary nurse prescribing					

Nurse prescribing research adopts a range of research approaches. An overview of methods finds an almost even split between quantitative and qualitative studies with around a quarter adopting mixed method approaches.

2.2: Nurse Prescribing: Views from nursing.

A key argument presented in the nurse prescribing literature says that before nurses had legal authority to prescribe they were already prescribing for patients. In this form of prescribing (prescribing by proxy) the nurse works independently to undertake a consultation, diagnose and make a prescribing decision. The doctor oversees the process by signing the prescription. This is not in legal terms accepted as prescribing but the process follows the same decision making process as prescribing. If, as it appears, nurses have taken prescribing roles in the workplace the idea that prescribing is as an appropriate activity for nurses' gains support.

Achieving legal authority to prescribe through prescribing policies was

therefore, the next step and a natural addition to the role of the nurse (Luker, Austin, Hogg et al 1997a; Nolan, Sayeed, Badger et al., 2001; Otway 2001; Rodden 2001; Lewis-Evans and Jester 2004; Latter, Mayben, Myall et al., 2004; Bradley, Campbell, Nolan 2005 ; Jones, Bennett, Lucas et al 2007). The idea that nurses were already prescribing in the workplace, even though it was by proxy, suggests that some change to the division of labour had already occurred.

Following the completion of prescribing education nurses found prescribing authority changed their professional role. Nurse prescribers in a study by Bradley and Nolan (2007) described how becoming a prescriber had changed the focus of their nursing role. Prescribing, they said, moved them from a caring towards a curative role, Bradley and Nolan (2007). Doctors traditionally adopt a cure model in their role. Baumann, Derber, Silverman and Mallette (1988) suggest cure models of care aim to identify pathophysiology, diagnose and reduce presenting symptoms through treatment. These are important factors related to safe prescribing and their inclusion will change the nurses' role. In a study by Bradley et al. (2005) nurse prescribers were reported to be unconcerned by the change towards cure models and accepted prescribing into their nursing role. Harrison (2003) and Jones et al. (2007) asked mental health prescribers if they thought the addition of prescribing might result in a shift towards drug therapy and a loss of core nursing roles. These nurse prescribers were also unconcerned about the change (Harrison 2003; Jones et al. 2007). Nurse prescribers commented that adopting medically orientated models into nursing models of care complemented the caring role of the nurse. Bradley et al. (2005) and Jones et al. (2007) argue that incorporating elements of a cure model actually enhances nursing roles.

It is interesting at this point to consider how Witz (2002) explains the significance of care, cure roles to nursing. She argues that traditional demarcations between the roles of doctors and nurses are based on "increasingly untenable distinctions between cure and care" Witz (2002 p 33). For Witz these distinctions are untenable because the content of medical and nursing work is subject to change and the boundaries of professional work blurred. In research nurse prescribers have described how changes to care, cure roles can enhance nursing roles Bradley et al.(2005) and Jones et al. (2007). Witz explores these concepts, starting with the premise that nursing embraces a people centred approach to care. This, she argues enables practitioners to establish a sphere of competence and autonomous practice. Within this sphere, the nurse makes informed judgements and decisions relating to patient needs. Through autonomous work, the nurse reclaims these activities from medical control. There are examples of nurses defining spheres in the prescribing literature. Bradley and Nolan (2007) identify wound care and diabetes as areas of expertise. Bradley et al. (2005) describe how nurses make prescribing decisions but do not sign the prescription. According to Witz these actions enhance the nursing role and she goes onto distinguish between enhancing and extending nursing roles. She describes how extended nursing roles enlarge the nurses' sphere of competence by incorporating medically derived tasks into nursing. Witz places the concepts of enhancing and extending in a wider social context. She suggests enhanced roles raise perceptions of holistic patient need and therefore reflect developments in healthcare philosophy. The approach is, described as "carative" Witz (2002 p 31). Extended roles reflect developments in healthcare organisation because they require less expensive models of healthcare delivery than the doctor controlled model. This is the "curative" model, which she also suggests requires a body of relatively abstract knowledge Witz (2002 p31).

For nurse prescribers the authority to prescribe is a positive addition to their role. However, the literature suggests that there is some concern amongst nurse prescribers about how others might receive this addition to their role. In 2004, Hay et al asked supplementary nurse prescribers to identify actual and potential conflicts supplementary prescribing might bring to the team. The supplementary prescribers stated that professional envy and redistribution of workload were the most likely causes of conflict. Nurse prescribers also fear resentment and negative attitudes towards their new role from nursing colleagues (Bradley and Nolan 2007; Courtenay and Carey 2008).

The views of non-nurse prescribers working in teams with nurse prescribers are represented in the literature and these nurses have mostly given positive views (Nolan and Bradley 2007; Buckley et al. 2006). Whilst these studies present a potentially one-sided view of the situation there is sufficient evidence to suggest there is some rivalry and negativity in practice. According to Shelley (2000) this attitude is not uncommon. Nurses who achieve progression are, often considered by their colleagues as not real nurses, Shelley (2000). Whilst in terms of nurse prescribing this may be little more than petty rivalry Otway (2002) says that peer support is essential to effective nurse prescribing. Courtenay and Carey (2008) take a step further suggesting an absence of peer support will at best hinder and at worst prevent nurse prescribing.

Nurse prescribers have also shown a concern for how doctors might receive nurse prescribers. This is not surprising as there are reports of medical opposition to supplementary and full independent nurse prescribing reported in the professional and public press. This concern also draws on a lack of medical awareness and knowledge about the policy development in

clinical areas. Nurses themselves have taken a primary role informing doctors of the opportunities and parameters of nurse prescribing (Stenner and Courtenay 2008; Green and Courtney 2008).

2.3: Nurse Prescribing: Views from medicine.

The medical view of nurse prescribing is, shown in contrasting terms in the grey and research literature. The list of medicines or formularies which the nurse and other non-medical prescribers are allowed to prescribe is a key issue which the literature suggests has a direct influence on medical opinion of, the acceptability of non medical prescribing. McCartney, Tyrer, Brazier et al. (1999) explain how, in the first wave of nurse prescribing doctors who were unfamiliar with the Community Practitioners' Formulary expressed great concern about nurse prescribing. The fact that this formulary includes mainly dressings and topical treatments allayed their fears according to McCartney et al.(1999). Evidence from the literature suggests that doctors are not concerned that nurses have authority to prescribe but they are concerned about what they can prescribe and whether they are adequately prepared to prescribe these drugs.

The most frequently cited medical opinion of nurse prescribing comes from a letter published in *The Lancet* (Horton 2002). In the letter, Horton describes the development of supplementary prescribing as "a dangerous uncontrolled experiment" Horton (2002 p1875). His views refer to supplementary prescribing, a new development in prescribing policy at the time. Under arrangements for supplementary prescribing non-medical prescribers have legal authority to prescribe all licensed and unlicensed medicines both on and off label. Prescribing off-label is, when a licensed medicinal product is, used in circumstances not covered by the licence. The patient specific clinical management plan includes a list of drugs that the

supplementary prescriber is authorised to prescribe. Prescribers and patient must agree to the plan before prescribing begins, DH (2005).

The formulary for nurse independent prescribing was at first restricted in an Extended Nurse Prescribers Formulary. At the time of the Latter et al (2004) study, independent prescribing allowed the nurse authority to prescribe from a limited formulary of prescription only medicines (POM). This group of medicines are only available to the public on prescription. In Latter's 2004 study doctors were asked their opinions and experiences of nurse prescribing, Latter et al. (2004). Doctors who participated warned their nursing colleagues not to underestimate the level of clinical knowledge required to prescribe the drugs listed in the Extended Nurse Prescribers Formulary, Latter et al.(2004). Some doctors, as Buckley, Grime and Blenkinsopp (2006) report, lay claim to knowledge required for prescribing. They imply that non-medical prescribers would be unable to learn this knowledge.

Extending nurses roles from the adoption of practical techniques such as prescribing by proxy to a formal change to the division of labour raises concern in the literature about the education and knowledge necessary to perform these activities. Doctors identify differences between teaching people how to do something and the individual being able to undertake the activity safely. One doctor described with concern how nurses undertaking extended roles might attempt to handle what is beyond their capabilities (Griffin and Melby 2005). Main, Dunn, Kendall (2007) interviewed general practitioners and nurse practitioners to explore how they perceive the current and potential role of nurse practitioner. Doctors were concerned that where nurses lacked experience and they relied on protocols to direct their actions. Scholes and Vaughan (2002) found common use of protocols

to guide clinical decision making by nurses in extended roles. This activity, they warned, led others to assume they could undertake the role without preparation or supervision. This illustrates the risk of reducing clinical decisions into a series of parts. Medical opinions raise important questions about the adequacy of prescribing education and whether prescribing should be an appropriate activity for all nurses or perhaps be limited to a certain few.

The speed of change to prescribing policies and the formularies for nurse and non-medical prescribing provide continuous momentum to the debate and a challenge to prescribing educators. The most recent expansion of prescribing authority in 2006 allow nurse independent prescribers authority to prescribe all medicines listed in the British National Formulary (BNF) including some controlled drugs. In response to this expansion, Avery and James (2007) suggest access to the full BNF has fuelled the debate about adequacy of training and suggest the rightful place for nurse prescribing education is within master level programmes of advanced nursing practice.

Adding a different dimension to the debate are the views of doctors who are working with independent extended nurse prescribers (Latter et al., 2004). Doctors said that they were happy to work with nurse prescribers and found them to be competent prescribers. In the discussion, section of her paper Latter points out that the comments doctors made were intended to relate specifically to the nurse prescriber with whom they were working. She notes that some doctors were reluctant to relate the opinions they expressed to nurses in general. However, where nurse prescribing is accepted the effectiveness of nurse prescribing is dependent upon the relationship between the doctor and nurse in the prescribing team.

2.3.1: The doctor nurse relationship.

The opinions of doctors presented in the prescribing literature reflect the historical view presented in the professions literature, which suggests the status, and employability of a nurse is associated with doctors' perceptions of the merits of individual nurses (Tosh 2007 p73). This issue has links to the acceptability of nurse prescribing to the medical profession. The nurse prescribing literature does not specifically explore doctor nurse relationships. The importance of a working relationship is however, mentioned in a way that suggests it is important. In 2002 study Otway found a lack of support from other healthcare professionals, including general practitioners was a barrier to nurse prescribing. Courtenay and Carey (2007) also reported 15% of their 1,992 participants identified doctors or pharmacists had expressed a lack of support or objection to nurse prescribing. It is unfortunate that neither of these studies provide further detail of their findings. The studies are however important when considered alongside the comments of doctors in the Latter study cited above (Latter et al.,2004). Together these findings suggest doctor and nurse must have a trusting working relationship to support the integration of nurse prescribing.

The notion of trust is present in nursing literature however, as in our everyday lives trust is generally, taken for granted with little or no exploration of the concept itself. In a study of doctor- nurse relationships in primary care Pullon describes the presentation of trust in the literature as "mentioned", Pullon (2008 p134). The presence of trust appears therefore to be an assumed precursor or static factor in successful doctor- nurse relations (Pullon 2008; Aldous and Hall 2001). As Sewell (2007) reports there are few papers and fewer research studies, which explore the concept of trust in nursing relationships. Most papers focus on the nurse-

patient relationship (Brown 2008; Sellman 2007) and it is surprising to find that trust in the doctor- nurse relationship has not been subject to detailed exploration in the nursing literature. Trust has been, highlighted as important in nursing relationships and attempts have been, made to develop a conceptual analysis of trust (Johns 1996; Meize-Grochowski 1984). Johns (1996) developed the earlier work of Meize-Grochowski and identified two perspectives of trust common to the nursing literature. In the first, a clinical perspective trust is, considered an important outcome of the nurse-patient relationship. In the second, trust is associated with outcomes and levels of effectiveness from an organisational perspective. The analysis is heavily criticised in terms of method by Gilbert (1998), who describe its philosophical flaws.

Summarising the state of theoretical knowledge and conceptualisation of trust Misztal (1996) concludes that modern social sciences have made no significant contribution to understanding the concept of trust or the conditions under which trust will thrive or struggle to survive. Despite attempts by Meize-Grochowski (1984) and Johns (1996) to analyse the concept of trust in nursing Hupcey, Penrod, Morse et al. (2001) argue that inconsistency and disagreement surround the conceptual definition. In the absence of substantial theoretical knowledge and an agreed concept of trust it is easy to see why nursing alongside medicine, psychology and sociology have made little impression on developing an understanding of trust. In a search for other ways to explore trust in nurse prescribing, I choose not to embed this discussion in a particular definition or concept of trust but focus instead on common attributes of trust.

Trust is an essential part of everyday life, it is the expectations we have, often unspoken, of colleagues, our family, friends, ourselves and of the

organisations and systems, we live and work in. Trust is complicated, multifaceted and difficult to understand, yet when trust is replaced by mistrust the outcome becomes visible. As Bok (1979 p 26-27) says of trust "when it is damaged the community suffers and when it is destroyed societies falter and collapse". A common defining element to everyday and sociological concepts of trust is the inclusion of expectation. Luhmann (1979) describes trust in terms of the confidence we have that our expectations will be met. Hupcey et al. (2001) develop these concepts to a point from which trust in nurse prescribing can be explored. "Trust is used to describe the nature of therapeutic relationships, an intrapersonal attribute, as well as quality of interprofessional relationships, it is thought of as a need, an obligation and a virtue", Hupcey (2001 p 283).

2.4: Nursing and Nurse Prescribing.

2.4.1. autonomy and legal authority.

Nurses have offered prescribing advice to doctors particularly in areas where the nurse is the expert. Wound care is such an area but increasingly specialist nurses advise on the drug management of long term conditions such as asthma, diabetes and mental health (Nolan and Bradley 2007). Nurses advise and in addition may prescribe by proxy (Bradley et al., 2005). Under this informal arrangement, the nurse will make a prescribing decision agreed with the patient and the doctor is, asked to sign the prescription. The activity enables the patient to receive the medicines they need from the nurse without seeing a doctor. The practice is particularly common in general practice. Whilst the nurse completes a consultation makes a diagnosis and a prescribing decision, accountability for the accuracy of the diagnosis and the appropriateness of treatment stays with the prescribing doctor. For nurses who are regularly prescribing by proxy to become a prescriber and take accountability for these prescribing decisions

is a small step. Gaining authority to prescribe for patients is seen as something they are already doing and therefore a natural addition to the role of the nurse (Luker et al 1997a ;Nolan, Sayeed, Badger et al 2001; Otway 2001; Rodden 2001; Lewis-Evans and Jester 2004 ; Latter et al 2004 ; Bradley et al 2005 ; Jones et al 2007).

The nurse prescribing literature presents prescribing as a positive addition to the role of the nurse. The majority of participants in nurse prescribing research are prescribers and the views of non prescribing nurses are not well represented. There is one useful study by Carey and Courtenay undertaken in a secondary care dermatology department. The study interviewed 12 doctors and 6 non prescribing nurses. The nurse respondents were mostly supportive of their prescribing colleagues but were keen to express their view that prescribing is not an appropriate role for all nurses, Carey and Courtenay (2009).

Prescribing policies developed between 2001 and 2007 have given all nurses who have been registered for 3 years or more (NMC 2006) the opportunity to train as an independent and supplementary prescriber (DH 2005;2006). It is reasonable to expect that as nurses have legal authority to prescribe they will have less need to consult with, or rely on doctors for prescribing decisions. There is only limited support for this assumption in the nurse prescribing literature

Rodden (2001) undertook a quantitative study of Community Practitioner Nurse Prescribers. She asked 90 participants to rate their agreement to a series of statements designed to establish their perceptions of autonomy and dependence on general practitioners. Almost half the respondents agreed with the statement "autonomy has increased" Rodden (2001 p351).

This however, leaves just over half the prescribers perceiving that prescribing authority has made no difference to their autonomy and feeling as dependent on general practitioners as they had before. Latter et al. (2004) also reported nurse prescriber perceptions of autonomy. In a national survey of extended independent prescribers Latter asked 246 prescribing nurses to rate their agreement to this statement; "nurse prescribers have greater satisfaction and autonomy" [than non-nurse prescribers] Latter et al. (2004 p106). She reports, 60% of respondents agreed with the statement. Whilst this does suggest that more than half of nurse prescribers feel they have more autonomy over prescribing decisions prescribing had not increased autonomy for 40% of nurse prescribers.

Bradley et al. (2007) also sought to identify perceptions of autonomy in prescribing teams. They asked 91 newly qualified extended independent nurse prescribers in a survey if they thought their colleagues would see them as having increased autonomy. They found only 18% of respondents felt colleagues would see them as more autonomous practitioners. Why prescribing nurses do not believe prescribing has increased their autonomy has not been subject to investigation in these papers. A plausible explanation can, however, be drawn from the literature. Shepherd, Rafferty and James (1999) said that, without autonomy in clinical decision making to accompany prescribing authority, prescribing is little more than role expansion. McCartney et al. (1999) question if the limited powers of prescribing from limited formularies available to nurse prescribers were of any value. The greater majority of products on these formularies were, at first classified under the 1968 medicines act as general sales list (GSL) or pharmacy (P) medicines. These medicines are on sale to the public and classified as not requiring a medical opinion to be sold. All three studies took place at a time when independent prescribing was subject to

significant restriction. Independent community practitioner and extended independent prescribing formularies include drugs and dressings such as wound dressings, catheters and analgesics used in everyday nursing practice. Authority to prescribe these items is not likely to afford the nurse prescriber increased autonomy. As McCartney et al. (1999) point out authority to prescribe such items does not authorise the use of professional judgement on a medicine that is normally restricted to medical control. I agree with Shepherd et al that prescribing from a limited formulary allows little more than role expansion (Shepherd et al., 1999).

2.4.2. prescribing safely.

Nurse prescribing raises questions of patient safety on several levels. At a professional level, prescribing is not at present regarded to be an appropriate activity for all nurses. The NMC (2006) set eligibility criteria for entry to prescribing programmes. There are few legal restrictions to what nurses can prescribe and the onus is on nurses to define his or her own areas of competence (NMC 2006; DH 2006). In the only study in the nurse prescribing literature to explore safety aspects of nurse prescribing Bradley et al. (2007) report that nurse prescribers feel an enhanced sense of accountability. Their participants were cautious and careful to prescribe within their sphere of competence. However, as Bradley et al. (2007 p603) said "the novelty of prescribing was felt to encourage caution and promote safe prescribing". At a practice level in the workplace, medical and non-medical prescribers are likely to be prescribing for the same patients. It can be argued that the more prescribers there are, the greater the potential for poor communication and an increased risk of medication error. Professional standards, prescribing policies and clinical governance systems are ways in which healthcare organisations manage this risk in the workplace. At an education level, defining the right level of knowledge to

support safe prescribing has been a key issue of professional concern from the beginning of nurse prescribing (Blenkinsopp and Savage 1999; Otway 2001; Fisher 2005). Questions have, in addition been raised in relation to the preparation of pharmacist supplementary prescribers. Hobson and Sewell (2006) say that pharmacy prescribers are concerned about both the teaching and assessment of clinical skills.

This important question continues to be raised as independent and supplementary prescribing policies expand and restrictions to non-medical prescribing are removed (Latter et al., 2004; Nolan, Sayeed, et al., 2001; Bradley et al., 2005; Bradley et al., 2007).

2.4.3. preparation to prescribe.

The nurse prescribing literature attempts to define the prescribing knowledge necessary to support safe prescribing. According to King (2004) and Leathard (2001) particularly in terms of pharmacology knowledge this has been difficult. The NMC have defined prescribing curricula in a series of documents (ENB 1998; UKCC 2001; NMC 2006). Drawing on prescribing curricula (NMC 2006), prescribing knowledge has six main components;

- taking a medical history
- taking a medication history,
- understanding pharmacological properties of possible treatments,
- the affects of drug therapies on other medications and side effects
- working within legal systems.
- Working within professional systems of prescribing.

NMC (2006).

Additional education requirements added to the most recent education standards require an 80% pass mark for pharmacology and a 100% pass numeracy test (NMC 2006). The indicative content for prescribing curricula

has not been subject to significant change since its inception. This suggests that curricula for nurse prescribing are, considered by the profession to be fit for purpose. There remains however, criticism in the literature that independent, extended and supplementary prescribing education does not adequately focus on the principles of pharmacology (Blenkinsopp and Savage 1999; Leathard 2001; Latter and Courtenay 2004; Banning 2004; While and Biggs 2004; Bradley et al 2007; Latter et al 2007). There are in addition questions asked at a general level about the appropriateness of nurse prescribing education. Courtenay and Carey (2007) found the programme of education did not meet the needs of 50% of the 246 diabetic specialist nurses in their sample group. Believing the curriculum is not appropriate to their education needs, several specialist groups of nurses have identified education needs for themselves. Tyler and Hicks (2001) used a training needs analysis model to prioritise training needs of family planning nurses. Pontin and Jones (2007) explored the views of children's nurses. Wright and Jones (2007) set up a mental health nurse prescribing course to meet unmet learning needs identified by this group of nurse prescribers. The education needs identified in the research papers focus on knowledge required to diagnose, treat or manage the conditions the prescriber will be seeing. The NMC (2006) expect nurses who come onto prescribing courses to have this knowledge before entry to prescribing education.

2.5: Nurse Prescribing: and the team

2.5.1. prescribing in teams.

The prescribing literature describes the effect of nurse prescribing on non prescribing nurses in clinical teams. The knowledge and skills nurse prescribers bring to the team are a focus for discussion in the literature. New prescribing knowledge has been, used as a resource in nursing and

wider healthcare teams, Bradley et al. (2005). Prescribing nurses welcomed the opportunity to use their knowledge in this way and described the opportunity as an advantage of nurse prescribing (Bradley and Nolan 2007). New prescribing knowledge was found to have positive effects on the team in studies by Hay et al. (2004) and Jones et al. (2007). The Jones et al. (2007) study of mental health nurse prescribers and psychiatrists found nurse prescribers to be more evidence based in their practice than other members of the team. The finding was attributed to recent prescribing training and in turn had a positive effect on the knowledge, skills and practice of the whole mental health team. This study (Jones et al., 2007) is one of a number in the literature suggesting that prescribing provides a prompt for teams to update their knowledge and the evidence base from which they work. Jordan, Knight and Pointon (2004) and Jones et al. (2007) go onto explain how nurse prescribing is a useful means for reducing professional distance, enabling nurse prescribers to work more closely with medical colleagues. Several studies have reported that where nurse prescribers work as part of a team their prescribing role has increased their opportunities to network with medical colleagues (Hay, Bradley and Nolan 2004; Bradley et al., 2005). Nurses improve their knowledge of medicines through prescribing education and according to Courtenay and Carey (2008) this knowledge gives nurse prescribers confidence to discuss the medicines management of patients with doctors.

According to the prescribing literature, teams can expect to experience several benefits from nurse prescribing. Time savings, are the most commonly expected and evaluated benefit in the literature. One of the leading outcomes of nurse prescribing determined by government (DH 1989; 1999a) was its potential to free up doctors time. The literature is inconclusive about the extent to which prescribing achieves this aim. Luker

et al. (1997d) draw directly on the patient response to conclude that nurse prescribing successfully alleviates the General Practitioner of some routine aspects of duty. It seems reasonable to expect that the development of prescribing in the ten years since the Luker study would continue to develop the time saving benefit. Latter et al. (2004) however found doctors also unable to conclude 'unequivocally' that nurse prescribing had reduced their workload. Comments from doctors in the study suggest the limited legal framework of extended independent prescribing in place at the time influenced their views. Because the formulary open to nurse prescribers at the time was limited, nurses continued to request prescriptions from doctors. There are no published studies of nurse prescribing from the independent prescribing formulary.

Nurses in the Bradley and Nolan study, (2007) confirm that nurse prescribing saves nursing time, particularly in terms of waiting for doctors to sign prescriptions. Lewis-Evans and Jester (2004) and Brooks Otway, Rashid, et al. (2001) found nurse prescribing additionally saved time for patients and speeded up their access to treatment, Bradley et al. (2005). This is, achieved by streamlining services and addressing fragmentation of care (Nolan and Bradley 2007; Buckley et al 2006; Bradley et al 2005; Nolan, Sayeed, et al., 2001). There are examples in the literature to suggest that moving patients through healthcare services is part of nursing work (Allen 2004; Annandale, Clark, Allen 1999). Prescribing may contribute to the effectiveness of this work, although further study is necessary to support this claim.

2.6: Prescribing in Practice.

The prescribing literature presents nurse prescribing in a positive light and these positive attitudes promote the general acceptance of nurse prescribing in public and professional arenas (Luker et al., 1997c; Nolan, Carr et al 2001; Otway 2001; Rodden, 2001). Concern is however, raised in the literature that not all qualified nurse prescribers actually prescribe for patients. The problem presents across community practitioner and independent and supplementary prescribing. Reasons are, given in the literature in an attempt to explain why nurses do not prescribe.

2.6.1. Community Practitioners who are not prescribing.

Community practitioner prescribing, integral to the specialist District Nurse and Health Visitor specialist award allows prescribing from a limited formulary. Community practitioners who choose not to prescribe say the formulary available to them does not meet their prescribing needs, Lewis Evans and Jester (2004). Health visitors in particular find the restricted formulary does not meet their needs. Some community practitioner prescribers completed prescribing education to appease pressure for employers but did not want to be prescribers (While and Biggs 2001).

2.6.2. Independent and Supplementary prescribers who are not prescribing.

The literature identifies a small number of independent and supplementary prescribers choosing not to prescribe. Latter et al. (2004) report 39 of 246 whilst Bradley and Nolan (2007) report 10 of 35 participants do not prescribe. The reasons offered to justify not prescribing are more diverse than those of the community practitioner prescriber and are presented in the literature as a group of factors that hinder, prevent and promote prescribing. The factors cover two broad areas, technical and professional.

Technical problems are the most frequently cited in the literature and are concerned with the administrative processes in healthcare organisations. No prescription pad, problems ordering pads, problems implementing clinical management plans, awaiting risk assessment, bureaucracy and not being able to generate computer prescriptions are reported (Latter et al., 2004; Bradley and Nolan 2007; Courtenay and Carey 2008). Technical difficulties restrict, delay and, for some nurses actually prevent prescribing, yet each has the potential to be resolved at an organisational level.

Professional reasons are more complex. The restricted formulary in place for extended independent prescribing from 2001 – 2006 is reported to hinder and prevent prescribing (Latter et al., 2004). The most frequently identified barrier to prescribing was the extended formulary for independent prescribing with around a quarter of nurses reporting it as inadequate. The issue of restricted formularies persists but it only affects nurse prescribers who wish to prescribe controlled drugs for non-palliative care patients. Whilst limited restrictions remain in place for independent prescribing there is evidence that restricted formularies are in use in healthcare organisations as part of a clinical governance framework. These restrictions, developed and implemented in the workplace are, identified in the literature to hinder, delay and prevent prescribing (Hall, Cantrill, Noyce 2004; Hay et al 2004; Courtenay and Carey 2008). Studies have shown that some doctors use guidelines and protocols as prescribing boundaries within which the nurse is expected by the doctors to prescribe (Latter et al., 2004; Buckley et al 2006). Some doctors said that they measured the clinical accuracy of nurse prescribing activity against standards and guidelines (Hay et al., 2004). Jones (2003) also identified from a series of focus groups in acute care that some nurses working in extended roles rely on protocols to guide their practice. Doctors participating in this study were

keen to point out that nurses need experience and training to recognise when the protocol is not appropriate for the patient. From such a small number of studies it is not possible to conclude that doctors expect nurse prescribers to prescribe within clinical protocols or guidelines. This area would benefit from further research.

Changing jobs and medical opposition are the factors most likely to hinder or prevent nurse prescribing. Medical opposition is an interesting factor, Latter et al.(2004) but this survey research gives insufficient detail to explore the nature of this opposition. It does however lead me to conclude the issue is likely to be specific to the prescribing nurse, doctor, their professional relationship and the clinical area of prescribing practice. The role of the nurse might be another factor of influence, however Latter et al (2004) and Courtenay and Carey (2007) included general practice, specialist and senior nurses in their samples. They do not identify or discuss issues related to nursing role or clinical environment in their findings or discussion. The fact that these issues are not, explored in the literature suggests they do not hinder, prevent or promote prescribing activity.

2.6.3. starting to prescribe.

There are no studies which describe how prescribers begin to prescribe once qualified. However embedded within the literature are examples to suggest how nurse prescribers might integrate prescribing. When nurse prescribers prescribe, their prescribing activities are, judged against the medical systems of prescribing familiar to professions and public. In a study of pharmacist prescribing, Weiss and Sutton (2009) suggest that prescribers might limit the range of clinical areas they prescribe for. This action does not reflect the medical system of prescribing. The prescribing

literature suggests, however, that nurse prescribers do not necessarily follow medical systems and, supported by the Nursing and Midwifery Council (NMC 2006), will not prescribe on behalf of doctors or other healthcare professionals (Bradley et al., 2005). Courtenay and Carey (2008) suggest nurses who are to prescribe for patients with co-morbidities favour the supplementary approach to nurse prescribing. Bradley, Hyman and Nolan (2007) cite an example where the nurse focussed on one or two drugs, becoming comfortable with knowledge and prescribing of the drug before expanding.

These examples give the briefest of insights about how nurses integrate prescribing into nursing practice. Importantly they do show that some nurses restrict their prescribing to start with in a form of staged approach. The restrictions they impose on their prescribing limit their prescribing to a small group of drugs and for certain patients but not others. This approach is not that undertaken by medical prescribers who prescribe for patients as need determines.

Findings from the Brooks et al. (2001) study of community practitioner prescribers gave the first indication that prescribing and consolidating prescribing knowledge changes over time. Their participants described how as experience developed they used prescribing in a wider range of clinical situations. The survey sample used by Courtenay and Carey included nurses qualified to prescribe for up to 2 years. They also found that confidence increased over time and frequency of prescribing (Courtenay and Carey 2008).

2.7: Nurse prescriber views of the prescribing role.

Nurse prescribers welcome the opportunity to take responsibility for patient care from assessment to prescribing without the need to refer to another professional. According to Jones et al. (2007) and Green and Courtney (2008), being able to complete episodes of care enhances the nursing role. Britten (2001) described prescribing as “a clear example of professional autonomy” Britten (2001 p479). The autonomy to prescribe is an acknowledgement of nursing skills and knowledge. Nurse prescribers use this knowledge in practice and are more confident when talking about medications, particularly with their medical colleagues (Bradley et al., 2007). Whilst the literature suggests that nurses have welcomed prescribing authority at the same time nurse prescribers express an underlying need for support in their prescribing role.

2.7.1. support in practice

Support emerges from the prescribing literature as an important determinant of nurse prescribing. The literature does not define support in nurse prescribing but I take it to refer to a relationship that is helpful, encouraging and understanding. The type of prescribing has no relevance to the need for support, as research related to community practitioner independent and supplementary prescribing all identified the issue. The literature highlights the need for support and gives examples of what might happen without support. Otway (2002) said a lack of support and understanding with regard to the prescribing role was a barrier to community practitioner prescribing. More recently, and in relation to independent and supplementary prescribing, participants in Courtenay and Carey’s (2008) national survey suggest poor peer support can prevent prescribing in practice. Once prescribing, Hay et al. (2004) found team support vital to enable nurse prescribers to use their prescribing role in full.

Although the literature identified the need for support, this literature gives no description of the form or frequency of support required.

Support from medical prescribers is subject to particular attention in the nurse prescribing literature. Courtenay and Carey (2008) found problems accessing a doctor would hinder or prevent the nurse from prescribing. Their survey question was not specific to independent or supplementary prescribing. However, doctors must sign their agreement to be involved in a supplementary prescribing partnership. Problems accessing doctors would therefore present a significant barrier to the development of a clinical management plan, required before supplementary prescribing can begin. It is not possible to determine from the survey if the statement is significant in terms of independent prescribing. In another survey independent and supplementary nurse prescribers working in Macmillan roles rated the need for initial and ongoing medical support highly, Ryan-Woolley et al.(2007). Participants in the Bradley et al. (2007) study also rated highly having a mentor [doctor] available to check clinical decisions.

The purpose of this need for support from within the team and the medical profession might actually reflect a lack of confidence by nurses in their prescribing abilities. The literature overall is inconclusive however, there is some support for the suggestion. Latter et al. (2004) found the majority of respondents in their study of independent extended nurse prescribing were confident prescribers. The remaining (small) number of nurse prescribers rated themselves as less confident in their ability to make a correct diagnosis and in their prescribing knowledge. As independent prescribing requires the nurse to diagnose the presenting condition low confidence may signify a need for support.

2.8: Public and Patient Acceptability.

Several papers specifically investigate nurse prescribing from a patient perspective but the views of patients are, almost without exception, discussed in all the prescribing literature. This attention reflects the point that patient acceptability and patient benefit were guiding principles for the extension of nurse prescribing (DH1989; DH1999a). Crown, in her two reports to the advisory group on nurse prescribing, set out how patients were, expected to benefit from nurse prescribing. Her commitment was clear, the development of nurse prescribing was not to be a matter of professional aggrandisement or practitioner substitution, but would benefit patients.

When researchers asked patients to comment on the acceptability of nurse prescribing they did so by drawing on the role of the nurse and talking about their own experience. Patients talked in positive terms about the relationship between themselves and the prescribing nurse. Nurses were described as being approachable (Luker, Austin, Hogg et al., 1998a; Brooks et al., 2001; Latter et al., 2004), central to the continuity of care (Brooks et al., 2001; Luker, Austin et al., 1997b) knowing the patient and patient centred in their approach (Luker et al., 1998a; Jones et al., 2007). In using these terms, patients pick out attributes of nursing they believe complement a prescribing role. Also important to patients was that they should have convenient access to medicines. Patients believe nurse prescribers enable this access (Luker et al., 1998a; Brooks et al., 2001; Latter et al., 2004).

Patient views were one of several data sets collected in ten case studies of extended independent prescribing, Latter et al.(2004). Researchers asked patients in receipt of a nurse prescription to complete a post- prescription

questionnaire. The study results do not offer details about whether the patients were new or existing service users. It is, however, acceptable to assume that across 10 case studies from primary and secondary care some patients will be new and some existing. Views from 118 patients were gathered. Patients said that they felt comfortable talking to the nurse, 71% of patients found the nurse was approachable and 61% specifically valued the continuity of care they experienced whilst receiving nursing care. Independent extended prescribing requires the nurse to establish a diagnosis before prescribing and the authors report that 91% of patient participants believed the nurse had correctly diagnosed their problem. This however, leaves a number of patients who did not believe the diagnosis was correct.

Latter et al. (2004) report 73% of respondents agreed that nurses should be able to prescribe more medicines. These two points, that not all patients believed the nurse diagnosis was correct and that most patients felt nurses should be able to prescribe more medicines, are important. Extended independent prescribing, which was the focus for Latter's research, required the nurse to diagnose minor illness and minor ailments.

Brooks et al. (2001) and Jones et al. (2007) refer to nursing expertise suggesting that expert knowledge and time to explain about medicines are suitable reasons to support nurse prescribing. Not all patients agree, patients in a study of mental health service users were concerned that nurses had limited knowledge on which to base prescribing decisions (Harrison 2003). At the time of this research, mental health nurse prescribers could prescribe drugs for mental illness but only under supplementary prescribing arrangements. Under supplementary prescribing arrangements the doctor is responsible for the diagnosis. In 2006 nurse

prescribers gained authority to prescribe these drugs under independent prescribing which requires the nurse to diagnose the condition before prescribing treatments. Berry, Courtenay and Bersellini (2006) conducted research using a clinical scenario that asked the public to imagine they were at risk of coronary heart disease and need a prescription. Their study focussed on supplementary prescribing under which the nurse can prescribe all licensed and unlicensed medicines. The drugs, which the nurse prescriber can prescribe, have to be included a patient specific clinical management plan. The doctor must make a diagnosis and agree a range of drugs suitable for supplementary prescribing. This arrangement can be seen to assure the patient that both diagnosis and drug therapies are appropriate because the doctor has been involved. The literature to date has not asked patients for their views on the nurse diagnosing and prescribing for patients with chronic diseases and complex or co-morbidities. From the available evidence, it is possible to assume patients will find this new prescribing acceptable however, we do not know. The literature suggests that patients are happy to consult with nurse prescribers but they also wish to retain a right to see a doctor when they feel it is necessary (Luker et al., 1998; Brooks et al., 2001; Latter et al., 2004; Berry, Courtenay, Bersellini et al., 2006).

Both patients and public (Berry et al., 2006) consistently voice an expectation that all prescribers give information about the drugs they prescribe, explain side effects and offer treatment choice. This expectation also relates to prescribing by doctors, Dickinson and Raynor (2003). The finding is significant to the development of prescribing and the integration of nurse prescribing in practice. To enter into these conversations with patients and meet their information needs the nurse must be able to apply theoretical prescribing knowledge to patient specific clinical situations.

Although patient and public acceptance of nurse prescribing is established gaps in the literature remain. Cooper et al. (2008), in a review of nurse and pharmacist supplementary prescribing literature, were surprised to find only a few published studies explore the opinions or experiences of patients in supplementary prescribing partnerships. The partnership between patient and prescribers is central to the concept of supplementary prescribing and fundamental to the development of a clinical management plan. The literature shows more concern with showing nurse prescribing to be acceptable to patients than in the patient experience.

2.9: International perspectives on Nurse Prescribing

The international nursing literature describes the development of nurse prescribing across several continents. It is important to recognise when reading this literature that there are significant differences in the drugs nurses can prescribe, healthcare systems and clinical environments for nurse prescribing across the world. Shepherd describes these differences as "difficulties in transatlantic translation" Shepherd et al.(1999 p 467). While she refers specifically to American and United Kingdom (UK) healthcare system the problem presents throughout the international prescribing literature. These difficulties led Latter and Courtenay (2004) to suggest international evidence is not compatible with UK nurse prescribing. These authors chose not to include international literature in their 2004 review of nurse prescribing. They were strongly criticised (Barrett 2004) and subsequent papers from Latter and Courtenay and others writing about non-medical prescribing include a brief and mainly arbitrary summary of the international nurse prescribing literature.

Internationally the consistent and dominant factor in allowing nurses authority to prescribe is the need to provide healthcare services in rural communities. This is particularly prevalent where limited medical services are available. America, Sweden, Australia, New Zealand, Uganda, Canada all have forms of nurse prescribing (David and Brown 1995; Saur and Ford, 1995; Nolan, Carr, Harold 2001; Wilhelmsson and Foldevi 2003; Nolan et al 2004 ;Logie and Harding 2005). In contrast to UK non-medical prescribing which affords the prescriber almost identical prescribing rights to doctors, internationally nurse prescribers work to restricted formularies (Wilhelmsson and Foldevi 2003; Buchan and Calman 2004; Logie and Harding 2005). The international literature tells nothing of how nurse prescribers start to prescribe or how nurses accept the autonomy and accountability of prescribing. The focus of the international literature is about restricted formularies and resistance from the medical profession.

2.10: Nurse Prescribing and the Blurring of Professional Boundaries.

According to Dingwall, Rafferty and Webster (1988) the history of nursing is full of struggles to define the role of nurses as something more than a handmaiden to doctors. As nurse prescribing becomes part of this history nurses take on an activity previously in the domain of, and almost exclusively associated with the medical role. The way that nurses led the request for prescribing authority is an example of occupational development. Witz (2002) suggests that where occupational development occurs it changes the relationship between nursing and medicine and relationships must be, redefined. There is evidence in the nursing literature to suggest that when healthcare professionals take on technical activities that have been previously associated with medicine professional boundaries become blurred and changes to the division of labour occur

(Tye and Ross 2000). This “blurring of professional boundaries” Currie and Crouch (2008 p 336) describes the changes to traditional role demarcations that occur when nurses take on medical activities (Bonner and Walker 2004). The blurring of boundaries between healthcare professions is becoming increasingly common as practitioners take on activities that previously undertaken by other professions, Masterson (2002). Research into extended nursing roles is most often undertaken in critical care and primary care settings where, in different ways, nurses are more likely to extend their roles with medically associated activities. Whilst this literature does not focus on prescribing, many of the activities of extended roles involve diagnostic decision-making. The knowledge and authority required to diagnose and prescribe are subject to description and discussion in this literature (Lockwood and Fealy 2008; Bonsall and Cheater 2007). The literature provides evidence to support the notion that the division of labour is redrawn and at the same time highlights the context within which these boundary changes become acceptable to the professions.

2.10.1. medicine and control over diagnosis and prescribing

Prescribing was once the sole domain of doctors, dentists and veterinary surgeons. In terms of the division of labour in primary and secondary healthcare settings, medicine held jurisdiction over prescribing authority. According to Britten (2001), prescribing is one of the core activities that until recently defined the medical profession from other healthcare groups. As nursing has gained prescribing authority, in particular independent prescribing status, the exclusivity of medical authority over diagnosis and prescribing is taken away. Witz (2002) argues that constraints placed on nurses’ aspirations by the medical profession have been overstated. In terms of prescribing this is probably so. The medical profession supported nurse prescribing and were only opposed to prescribing policy

developments when they considered changes a potential threat to patient safety (Lacobucci 2006; Horton 2002). It was the broader environment of state directed health policy, Witz (2002) that determined the extent to which nurses' demands were realised.

The integration of prescribing into practice, by nurses and other non-medical prescribers requires a boundary shift, a redrawing of the division of labour. Participant responses from doctors in the nurse prescribing literature cite the autonomy and authority to diagnose and prescribe as defining features of medical work. Studies of nurse–doctor boundary work undertaken before independent nurse prescribing in 2001 cite diagnosis and prescribing as distinguishing factors between medical and nursing work, Allen (1997); Snelgrove and Hughes (2000).

2.10.2. doctor and nurse perceptions of changes to the division of labour.

In a study of three general hospitals in South Wales, Snelgrove and Hughes (2000) conducted semi structured interviews with 27 doctors and 50 nurses to gather perceptions of role overlap. Their respondents were able to locate their position within the hospital division of labour. Doctors in particular drew sharp distinction between medical and nursing roles emphasising their control over diagnosis, treatment and prescribing. Nurses were less certain of their role parameters, Snelgrove and Hughes (2000). They were reluctant to describe themselves as autonomous preferring instead, to portray a subordinate role to medical authority. The positions they described were a reflection of traditional roles and were not therefore an accurate description of clinical activities and responsibility in the workplace. Doctors expressed their views clearly. Diagnosis and prescribing were the responsibility of the doctor. Doctors allowed nurses to

take part in these activities but the autonomy and responsibility for prescribing decisions stayed with the doctor.

Autonomy is concerned with the authority and freedom to act and to make decisions. Freidson uses the term 'organised autonomy' to describe how an occupation can successfully gain a privileged market position by achieving control of its own work, Freidson (1970. p188). He argues that autonomy is the core of professional activity and an attribute, which can distinguish an occupation from a profession.

" a profession is distinct from other occupations in that it has been given the right to control its own work...Unlike other occupations. Professions are deliberately granted autonomy, including the exclusive right to determine who can legitimately do its work and how it should be done" Freidson (1970. p71-72)

As discussed previously, the autonomy and responsibility for diagnosis and prescribing decisions has enabled the medical profession to define its status and position in the hierarchy of professions. Most healthcare work depends on the diagnosis and treatment decisions made by the doctor. Freidson describes professional power in two dimensions, autonomy or the ability to control its own work activities and dominance or control over the work of others. Using autonomy as an attribute from which to define professional status categorises nursing as a semi profession, Abbott and Meerabeau (1998) or subordinate profession, Abbott (1988). According to Witz (1992), gender is integral to the definition of a semi or subordinate profession. Etzioni (1969) describes two defining features of a semi profession, an occupation located in a bureaucratic organisation and one in which women predominate. Witz (2002) explains that the semi profession

thesis is, based on an androcentric model of a profession that takes the successful projects of men at a particular point in history to be the paradigm of profession. This classification of a hierarchy of professions is, based on the characteristics of old and established professions such as medicine and law.

The approach is, referred to in the sociology literature as the trait approach, Macdonald (1995). Popular up to the 1970's sociologists have since questioned their role in defining professions and the approach has become outdated (Macdonald 1995). Freidson, in his later work concludes that decisions about whether one occupation is more or less a profession than another is not a task for sociology, Freidson (1983).

Evidence from the literature suggests that there are differences between a traditional division of labour and the actual division of labour in the workplace. The actual division of labour enables the nurse to undertake medical activities not formally acknowledged in the traditional roles and responsibilities of the nurse. There are examples of these arrangements in the literature (Bonner and Walker 2003; Currie and Crouch 2007).

2.10.3. new divisions of labour; investigating doctor nurse interactions.

Hughes (1988) used Steins work on the doctor-nurse game as a starting point to "investigate situations where nursing work was at odds with the traditional and subservient role of the nurse", Hughes (1988 p3). Hughes had noted that nurses undertook much of the early processing and triaging work considered at that time to be a medical role. He suggested this moved nursing work closer to the task of diagnosis. Stein studied doctor-nurse interactions in his frequently cited work "The Doctor Nurse Game"

Stein (1967 p 699). His early work described a game in which he observed doctors must seek a recommendation from the nurse but must not appear to ask and a nurse must communicate recommendations without actually recommending. Hughes did not find evidence of a game in play and found nurses to be generally open and straightforward in discussions with doctors. He suggests in his conclusion that the nature of the clinical environment and the system structures that order the throughput of patients serves to weaken medical dominance and allow nurses an open contribution to decision making. Acknowledging that there had been major changes in doctor- nurse relationships since the first publication (Stein 1967) Stein revisited the game in 1990 (Stein, Watts and Howell 1990). This time he talked of new more, equal relationships and encouraged nurses and doctors to work towards mutual interdependency.

For his study of doctor-nurse interactions Svensson (1996) dismissed the doctor- nurse game as a poor tool for understanding doctor-nurse relationships. Instead, he adopted a negotiated order perspective to investigate the interplay between doctors and nurses (Svensson 1996). He interviewed qualified nurses working on surgical and medical wards in five Swedish hospitals. Svensson suggests changes to the context of negotiation have opened opportunities for nurses to reorganise their work within organisational constraints and to influence clinical decision making more openly.

Allen (1997) examined nursing work across five occupational boundaries including that of doctor and nurse. Her ethnographic research examined how nurses on a medical and a surgical ward in a UK hospital managed the boundaries of their work. Unlike Svensson, Allen used participant observation in her data collection strategy. Significantly, her results found

discrepancies between interview and observation data. The interviews revealed uncertainty and disagreement about the changing division of labour but field observations showed little evidence of this in day to day doctor nurse interactions. She goes on to say that the day to day constitution of the nursing and medicine boundary is a product of meaningful actions and not the result of interactions between healthcare practitioners. From this perspective, a new division of labour is more likely to develop out of practical roles, which get work done and less likely to result from formal negotiation.

The idea that changes to the division of labour are not subject to formal negotiation but are, as Allen suggests, a product of meaningful actions is an interesting one. Svensson (1996) and Allen (1997) describe ways in which nurses organise and manage the flow of doctor's work and move patients through healthcare systems.

The actual division of labour in the workplace allows this to happen, Hughes (1988). Considered from this perspective individual attributes and the nature of the doctor nurse relationship are factors likely to influence boundary changes in a division of labour. Using a case study approach to evaluate the emergency nurse practitioner role in a major A&E department Tye and Ross (2000) identified individual variation in the approach of individual nurses to extended roles. Two practitioners were identified who had the same length of clinical experience in the department. One practitioner spoke of feeling isolated and demonstrated a lack of confidence when undertaking activities previously performed by doctors. The other was confident in the extended role. Currie and Crouch (2008) also identified variation between individuals. They conclude the absence of formal standardisation and regulation means that changes to the division of

labour comes down to a personalised relationship between doctor and nurse.

2.11: The Division of Labour: key points.

Through the literature, I have established that expanding the clinical role of the nurse requires some adjustment to the division of labour. These divisions are established over time and to some extent can be considered to reflect public expectations of each role. For example, in the study by Snelgrove and Hughes (2000) doctors described themselves as the carriers of medical knowledge on which the management and treatment of patients depended. Central to the division of labour between medical and nursing work presented in this literature are the activities of diagnosis and prescribing (Allen 1997, Snelgrove and Hughes 2000). Doctors cite the autonomy and authority to undertake these activities as a boundary or division between nursing and medical roles. Allen (1997) found that doctors were happy for nurses to take over some activities but were reluctant to relinquish diagnostic activities considered focal tasks of medicine. It is useful now to explore the claim of nursing for jurisdiction of prescribing.

2.12: Systems of professions and the division of labour

In his book 'the System of Professions Division of Expert Labor' Abbott (1988) describes the process by which professions control and maintain the boundaries of the profession. Authors exploring the division of labour (Svensson 1996; Allen 1997; Nancarrow and Borthwick 2005) have cited Abbott's work. Summarising the contribution Abbott makes to the sociology of the professions literature. Hartley (2002 p180) explains, "Abbott's work outlines the process through which professional dominance may be

challenged". Freidson agrees; "Abbott analyses the process by which occupations gain, maintain, adjust and lose their exclusive jurisdictions over particular tasks and largely functional factors involved in that process", Freidson (2001 p6).

In general, terms a profession is an occupational group with a specialised abstract skill that requires a period of extensive training. From this description, Abbott (1988) outlines his system of professions and division of expert labour. He starts with a system of professions. Each profession has a boundary of jurisdiction within which it must act. These boundaries reflect public, political and legal expectations of members of the profession. His theory works on the premise that there will be competition between professions to claim tasks within the jurisdiction of other professions. Movement of jurisdiction in one profession will directly affect the boundaries of other professions with similar or shared jurisdiction. This inter-related approach reflects the functionalist thinking of Durkeim, each part of society has functions that are interrelated and dependent on other parts (cited by Hollis 2002). In the same way Abbott's system of professions is dependent upon the inter relations between the professions. A change in one will affect the boundaries of others irrespective of whether or not they are full or, what Abbott terms subordinate professions, Abbott, (1988). The addition of prescribing to the role of the nurse has not only changed the jurisdictional tasks of nursing and medicine, but in addition those between medicine and other healthcare professionals and nursing and other healthcare professionals.

I presented, very briefly, earlier in this chapter trait theories for the classification of professions and, identified autonomy as a leading attribute in the classification of a profession. Abbott also uses autonomy to define

the jurisdiction of a profession. He explains, because medicine has autonomy and control over its work, it has professional status. According to Abbott, nursing does not have autonomy or control of its own work and in Abbotts system is a "subordinate profession with limited jurisdiction" Abbott (1988 p71). Jurisdiction is the division of labour and "defines the link between a profession and its work" Abbott (1988 p 20). He argues that in order to establish authority to control its work an occupation must claim, secure and maintain jurisdictional ties. The ties of jurisdiction are groups of tasks and together these form the jurisdiction of a particular profession. These ties are important because jurisdictional boundaries between professions are bound to a set of jurisdictional ties. Prescribing was a task embedded in the jurisdictional ties of medicine and was not a task associated with the jurisdictional ties of nursing. The outcome of disputes for control of jurisdictional ties is, said by Abbott, to depend on the way in which the profession manages and controls claims to knowledge and jurisdiction. The most effective way to control and manage knowledge claims, suggests Abbott, is by developing practical techniques. Here the controlling profession through abstraction of knowledge generates practical techniques through which the activity can be delegated (Abbott 1988). Through delegation, as opposed to the transfer of jurisdictional ties, a profession can maintain occupational control over the tie. Prescribing by proxy is an example of practical technique delegation between doctors and nurses.

Abbott explains how a profession makes a claim for jurisdiction of a task already associated with the jurisdictional ties of another profession. He describes the process in the context of American systems. Claims for jurisdiction in America are made first in the public arena and if supported are decided on by the state. Public claims rely in part on the public image

of an occupation, which as Abbott (1988) points out changes slowly. The result is that claims of jurisdiction in America can take decades to resolve (Abbott 1988). It is important here to point out that whilst Abbott does talk about jurisdiction with reference to the healthcare system in England, when he talks about claims for jurisdiction he refers to American systems. Claims for jurisdiction are in England and in Europe settled by government (Allen and Hughes 2002). In terms of nurse prescribing the claim in England required primary legislation and statutory order to pass through the parliamentary system. The government has mandated a change to who has authority to prescribe.

2.13: Positive outcomes for nursing.

Opportunities to extend roles in nursing are welcomed (Pearcey 2007; Currie and Crouch 2008). However, nurses express some concern that in doing so they accept roles that doctors no longer want to do (Pearcey 2007). Studies identify where nurses experience positive outcomes as a result to extending their roles. Jones (2003) report a general agreement amongst participants that nurse-doctor relations had improved, doctors reported that they had more time to see complex cases. Nurses found that doctors regarded them as more skilled and were more willing to collaborate with them. Currie and Crouch (2008) found that working at blurred boundaries prompted collaborative working, which study respondents reported as a positive outcome.

2.14: Nurse prescribing and the division of labour: Summary.

This review of the nurse prescribing and professional boundary literature highlights a number of important debates. From the prescribing literature, it is possible to conclude that nurse prescribing has been a successful policy initiative implemented in primary and secondary care practice. The

acceptability of nurse and non-medical prescribing to doctors, patients, public and other healthcare professions is, established through the literature. Benefits expected to arise from prescribing policy developments have also been realised and patients can now access prescribers in a wide range of acute and community settings.

Within nursing, the development has been largely welcomed although there is some evidence of professional rivalry in prescribing teams. Early concerns that prescribing would force nursing away from its caring tradition towards medically orientated cure roles are not, reported in the literature. There are examples in practice which suggest nurses are actually embracing the cure elements prescribing affords their role and using these successfully to extend their role in a nursing framework. The most frequent area of debate is that of accountability and responsibility associated with the authority to prescribe. Whilst nurse prescribers expected to experience increased autonomy, the reality for some has been a series of constraints in force to reduce and, in some cases remove this autonomy. Education and the knowledge required to prescribe safely is of concern to medicine and this is borne out in the literature. Prescribing and diagnosis were cornerstones by which the medical profession defined and defended its position in the hierarchy of healthcare professions. The boundaries between the medical and nursing professions have shifted and in the case of prescribing, the division of labour between doctor and nurse is redrawn.

2.15: The integration of nurse prescribing; gaps in the literature.

The prescribing literature evaluates the implementation of the non-medical prescribing policy initiative. The majority of work explores perceptions and prescribing activity within extended independent and supplementary

prescribing frameworks. The broad nature of formulary expansion brought about by the removal of restrictions to nurse and pharmacist independent prescribing in 2006 means findings from the early literature do not accurately reflect the framework of prescribing in place today. Patient views are considered in a number of studies but as Cooper et al. (2007) rightly points out there are no studies of patient views or experiences under supplementary prescribing arrangements. There are reports that nurse prescribing is a challenge to the hierarchy of medicine and a route to advance the professional project of nursing. The professions and prescribing literatures offer little in support of this claim. The professional boundary literature identifies a willingness from doctors and nurses to change the division of labour. These changes are necessary to allow nurse prescribers to use their prescribing knowledge and to prescribe for patients.

My interest lies with how nurses integrate prescribing into their practice. Published studies do not address the question of integration directly nor do they describe the process of integration. There are however, a number of factors, which the literature suggests hinder, prevent or promote nurse prescribing. It is likely that these factors will influence the integration of prescribing but whether or not they determine the integration of prescribing is unknown.

2.16: Research Outline.

The research question develops from observation and discussion with nurse prescribers and findings from this review of the prescribing and professional boundary literature.

2.16.1. research question: How is nurse prescribing integrated into primary and secondary care from a nursing perspective?

2.16.2. title of study: The integration of nurse prescribing; case studies in primary and secondary care.

2.16.3. aims and objectives.

aim: The aim of this study is to investigate how nurse prescribing is integrated into primary and secondary care.

objectives :

- Describe the methods of integration.
- Identify and explore factors from the nurses' perspective that determine if and how prescribing will be integrated.
- Identify through case studies the effect length of time qualified to prescribe has on the integration of nurse prescribing in practice.
- Contribute to the evaluation and development of prescribing education by description and analysis of integration during the consolidation period of prescribing education.

CHAPTER 3 : Methodology.

3.1: Choosing the research method.

Flick (2006) and Patton (2002) emphasise the importance of this stage of research design and I began as Patton (2002) suggests by clarifying the purpose of my research. My research question sets out to investigate how nurse prescribers integrate prescribing in primary and secondary care, nursing practice. During the process of integration, the nurse must agree a prescribing role in the team and redraw a new division of labour in the workplace. The purpose or aim of my research is to describe how integration occurs. Then, through these descriptions begin to understand why the integration of nurse prescribing varies between prescribers and to contribute to theory development. According to Patton (2002) the approach I describe is basic research and a useful approach for generating theory.

Two key points, drawn from the research aim, influence my choice of research method. First, in order to describe the integration of nurse prescribing I needed to find out how nurse prescribers actually go about integrating prescribing in practice. The prescribing literature identifies several factors reported to hinder, promote or prevent nurse prescribing. I needed to investigate how and why these factors affect prescribing and to explore the circumstances within which they might influence the integration of prescribing. In order to gather descriptions from nurse prescribers the research method must enable and encourage participants to speak about their own experience of integration.

Secondly, newly qualified nurse prescribers had spoken to me in conversations about their plans to integrate prescribing in their area of nursing practice. Party to their conversation they described how, two

nurses employed by the same healthcare employer and in the same nursing role made different decisions about how to integrate prescribing in practice. In order to begin to identify how and understand why integration differs between prescribers the sample must recruit prescribers working in a variety of clinical settings. Central to developing an understanding of why these differences occur was both the prescriber and the clinical environment within which the new prescriber agrees the division of labour. The clinical environment is therefore an important element that needed to be included in the study. A suitable research design should therefore invite nurse prescribers from a range of clinical areas employed by different healthcare organisations.

In Table 3.1 Yin (2003) offers a useful guide to assist the researcher when choosing an appropriate research method. The table headings start by asking the researcher to classify the research question by type. My research question asks how and why and I start at this point of the table.

Table 3.1: A table to help researchers choose an appropriate research method. (Yin 1994)

Strategy	Form of research question?	Control over behavioural events?	Focuses on contemporary events?
Experiment	How why	Yes	Yes
Survey	Who, What, Where, How many, How much	No	Yes
Archival Analysis	Who, What, Where, How many, How much	No	Yes / No
History	How, Why	No	No
Case study	How, Why	No	Yes

Working through the boxes in the table, three potential research methods emerge as suitable approaches to answer my research question. The three are experiment, historical study and case study. A lack of detailed evidence in the non-medical prescribing literature about how nurse prescribers integrate prescribing in practice means that experiments are not suitable. Nurse prescribing has a short history and is therefore not suitable at this time. Using Yin's table, case study method is the most appropriate and, he suggests the preferred research method to answer how and why type questions. In a continuing exploration of research methods, I explored the use of case studies in healthcare research.

Fitzgerald (1999) suggests case studies are a useful research method for those wishing to answer the 'why' questions which emerge with the adoption of new practice. Whilst nurse prescribing is not new, nurses have been able to prescribe for ten years, we are not able to explain why there are differences in the way nurse prescribers integrate prescribing. Bryar argues that "case study research has a considerable contribution to make in developing effective healthcare", Bryar (1999 p 62). Her paper explores the suitability of case study method in healthcare research and she cites several examples of case study method used to research developments in nursing practice. One of these studies is particularly interesting. Dopson, Miller, Rawson, Sutherland (1999) used case study method to identify factors which influence the clinical practice of nurses. Dopson states in the concluding remarks of the paper that we must recognise the influences on individual practice are both varied and subtle, Dopson et al.(1999). His view reflects my own thoughts that there are likely to be many factors that influence the integration of prescribing. Some factors will be specific to the nurse and some related to the clinical area of practice. Using a case study approach Dopson et al. (1999) were able to identify factors which influence

the adoption of new practice from single cases. Identifying factors of influence at single case level was potentially a useful approach to describing the integration of nurse prescribing.

3.2: Case studies of nurse prescribing.

In the preceding section case studies emerged as the most appropriate choice of method for this research question. These case studies of nurse prescribing set out with the aim of describing how nurse prescribers integrate prescribing into primary and secondary care. The chosen method provided me with the opportunity to choose single or multiple case design within a quantitative or qualitative research approach (Luck, Jackson, Usher 2006). Two writers, Yin and Stake dominate the case study literature and over the last decade, their work has influenced the acceptability of case study as a research method. Yin (2003) argued that researchers must distinguish between quantitative and qualitative research based on different philosophical beliefs rather than types of evidence. He shows greater concern in his desire to establish case study method as a credible method of research than he shows favour to the adoption of either quantitative or qualitative approaches to case research.

Quantitative approaches draw on the ontological assumption that the world is real and that reality can be, studied. Quantitative research traditions impose controls on research to minimise bias and maximise the reliability and validity of research (Polit and Beck 2004). Quantitative researchers use deductive reasoning to identify causal relationships. If I were to adopt a quantitative approach to these case studies, it would enable me to identify causal relationships between the factors reported in the literature to promote, hinder and prevent prescribing. However, the literature review identified a small number of factors and there is at present insufficient

evidence to suggest that these are the only factors to influence the integration of prescribing. As Rubin and Rubin (2005) state, quantitative methodology seeks to extract simple relationships from complex social worlds, searching for rules and uniformity with little concern for context. A quantitative approach would exclude the opportunity to identify other factors, which might promote, prevent or hinder prescribing. I have previously highlighted the potential influence of the clinical environment on the integration of nurse prescribing. This key factor is central to the choice of case study method and I reached the conclusion that quantitative methodology would not provide the depth or breadth of data necessary to answer my research question.

Based on the exploratory nature of the research question (Polit and Beck 2004; Gribich 1999) my case studies will adopt a qualitative research methodology, which seeks to develop an understanding of human action in social settings. According to Polit and Beck (2004) the naturalistic paradigm of qualitative research develops from the ontological assumption that reality is not fixed but exists within a context where there are multiple interpretations of reality. Drawing on over ten years experience in prescribing education I believe that whilst one factor can prevent the integration of prescribing the knowledge and assumptions underpinning this decision are likely to be complex. Qualitative methodologies emphasise there is no single interpretation. In terms of prescribing, the activity of prescribing has common or generic characteristics regardless of nursing role or area of clinical practice. There are however also significant differences. For example, the approach to consultation, patient and patient groups, healthcare setting, employers, doctors, knowledge and beliefs. Any one of these might influence decisions about how prescribing is integrated.

My qualitative case studies lead from a philosophical position which accepts that the ways in which people construct and make sense of their worlds and their lives is highly variable and locally specific (Flick 2006). It was my aim in choosing case study method to describe and develop an understanding of how nurse prescribers integrate prescribing in different healthcare settings within primary and secondary care. These characteristics favour qualitative methodology which explores a phenomenon (nurse prescribing) within its context (clinical setting and employing organisation) and assumes that this is of significance to the phenomenon (the integration of prescribing in nursing care and practice (Gerrish and Lacey 2006). The context of nurse prescribing, that is the environment in which it occurs is an important element of my research. To integrate prescribing into practice the nurse must agree prescribing boundaries with doctors and redraw the division of labour in the workplace. To find out how nurses integrate prescribing and why they chose a particular approach the nurse must be the central focus of the case. Case study method provides an opportunity in this research to investigate the integration of prescribing in a way that pays attention to, and respects the nurse prescriber, the clinical environment and the unique nature of nursing.

3.3: Types of case study

There are many types of case study. Some types define the focus of the case, historical for example, Robson (2002). Others prefer only to distinguish by research tradition and define case studies as quantitative or qualitative, Patton (2002; Huberman and Miles (2002). Whilst simple to understand these headings are not very helpful to researchers looking to design case study research. Yin (1994;2003) and Stake (1995) take a more structured approach to define case study types and apply the same

criteria to single and multiple case study types. As the researcher, I must choose the most appropriate type for the purpose of this study. Yin (1994) and Stake (1995) suggest single case studies are best suited to unusual, rare or critical cases. A single case study will describe in depth how one nurse integrates prescribing but it will be almost impossible to choose a rare or unusual case as little is known about how prescribing is usually integrated. According to Yin (1994), the most useful advantage of choosing a multiple case study approach is its regard for producing more compelling and robust results than those of single studies. I want to take this advantage and choose multiple case studies to describe, how nurses, working in a range of clinical areas integrate prescribing.

From this basic distinction of single and multiple case studies, the two writers take different approaches. I choose to align my study here with the work of Stake (1995). He defines three types of case study, intrinsic, instrumental and collective. The headings used by Stake reflect the interest of the researcher and therefore the purpose of the case study.

Instrumental case studies use the cases themselves as a route to investigate a topic of interest. Applied to my research, instrumental case studies allow me to focus on finding out about the integration of nurse prescribing by investigating single cases in a multiple case design. Stake describes the approach as an instrumental case study where each case chosen has purpose to help understand something else. More than one case will be required in order to describe how the integration of prescribing in primary and secondary nursing care occurs. Using Stake's types of case study a collection of instrumental cases will be required. It is likely that my cases will share common characteristics such as employer or role. Stake describes a collection of instrumental cases sharing common characteristics as a 'quintain' (Stake 2005 p6). Each case in the quintain is explored and

ordinary prescribing activities noted in order to pursue the external interest to explore the integration of nurse prescribing. This multiple case study method allows the researcher to choose individual cases that according to Stake (1995) should be similar yet unique to the study. I intend this exploration will lead to an understanding of the integration process in a variety of healthcare settings and nursing roles.

3.4: Defining 'the Case'.

Yin strives to establish case study as a credible research method and encourages the case study researcher to adopt the forms of justification and robust questioning associated with quantitative research design, Yin (1994; 2003). He comments, that case studies are stereotyped as a "weak sibling among social science method", and encourages case study researchers to adopt empirical rigour at the planning and design stage of research, Yin (1994 pxiii). Defining what is and what is not a case is a key part of case study design. Both Yin and Stake agree on the importance of careful case definition and provide the researcher different but complementary approaches to achieve this. To define these case studies of nurse prescribing I draw on ideas from both authors. Yin's determination to establish qualitative case study as a robust and credible research method leads him to encourage the researcher to address issues such as validity and reliability in case study design. Stake shows a greater interest in defining the type and purpose of case study research. The two do however agree that defining the case is one of the most important aspects of case study research. Whilst Stake describes the need for bounded and specific cases, Yin defines cases as units of analysis and study propositions. Both of these approaches focus the researchers mind on defining the case. Identifying why it is a case and what the researcher will examine in the case study. According to Yin, successful case definition will go some way to

avoiding the most common criticisms of case studies that “they take too long and result in massive unreadable documents”, Yin (2003 p11).

Stake (1995) takes the stance that not everything is, or can be a case. A case to Stake must be bounded and specific. He warns the researcher against adopting unbounded cases stating that without limits or boundaries the case is impossible to study.

“the case is something special to be studied, it is not a problem, a relationship or a theme”. Stake (1995 p 133)

A study of the integration of nurse prescribing is unbounded and therefore difficult or impossible to study. There is however, according to Stake, a way to bound unbounded subjects such as mine. He explains that where people become ‘the case’ the study enables the explanation of events, processes, relationships and problems within the context of the case therefore enabling what would otherwise be unbounded and difficult to study.

Yin describes units of analysis not cases and avoids discussion of bounded or specific systems, Yin (1994; 2003). He too warns the researcher to avoid topics not easily defined in terms of a beginning and end point.

Topics without a clear beginning or end are in effect unbounded. Yin introduces the term ‘theoretical propositions’ to case study design.

Theoretical propositions identified by the researcher at the design stage of the study frame the sampling strategy and follow through to data analysis, to ensure the collection of relevant data. Their purpose is to focus attention on areas of investigation within the scope of the study. Yin (2003) suggests that case studies without propositions lead the researcher to attempt to cover everything involved with the case and result in an impossible study.

A study of the integration of nurse prescribing in primary and secondary care has many potential variants and is therefore an unbounded system (Stake 1995). There are theoretical propositions in the form of common factors reported in the literature to hinder, promote and prevent nurse prescribing. The most commonly cited of these are, employment in primary or secondary care, employer and clinical role. The factors represent the theoretical propositions and a focus for these case studies. Using Stakes definition, the nurse prescriber is the case. Placing the focus on a person, the integration of prescribing is bounded and specific to the prescribing practice of the nurse. Each case in this quintain of case studies shares the concepts of nurse, prescriber and employed in primary or secondary healthcare services. The study proposition investigates how in each case the nurse prescriber integrates prescribing in practice. What makes these case studies as opposed to a collection of interviews is the prescribing context in which the case is studied. Each case builds a picture of integration and together cases contribute to understanding the process of prescribing integration.

3.5: Generalisability in case study research.

It is not my intention to generalise findings from these case studies to other nurse prescribers. It is however, my intention through these case studies to describe the process of prescribing integration in a way that enables readers to transfer this knowledge if they so wish and to begin to understand how integration occurs. The importance of being able to generalise from case study research is subject to debate in the literature. According to Yin (1994) knowing whether or not a study's findings are generalisable beyond the immediate case is a major barrier to case study research. Schofield (2002) suggests that a major factor contributing to the

disregard of generalisability in qualitative methodological literature is that it is both unimportant and unachievable. Highly regarded qualitative researchers such as Denzin (1983) also reject generalisability as a goal of qualitative research. The work of Cronbach (1975) is useful to consider at this point. He compared generalisation in natural sciences with the possibilities offered by social and behavioural sciences. He suggests that one of the big problems in trying to make work applicable to even the near future is that people and institutions change, Cronbach (1975 p187). The point is pertinent in the context of continual modernisation in the NHS and continual development of prescribing policy for non-medical prescribers. Although Denzin rejects generalisability, he emphasises the importance for every topic to have its own logic, sense of order, structure and meaning. Case study researchers have however devised methods to take account of the generalisability problem, Stoecker (1991).

Yin, in pursuit of empirical rigour favours replication logic. The logic builds on the idea that theory can be used to test case replication. Where replications are, identified in the population Yin believes research results might be, accepted for a much larger group without further replication. I discuss the idea of replication in more detail when I consider sampling. For Platt (1988) the issue with case study research should not be to question whether generalisability can be, achieved but what can reasonably be generalised to what. Stake explains that case study researchers are not required to provide generalisations but to describe the case in sufficient detail for the reader to take responsibility for generalising. Stake (2003) argues that instrumental case studies do not avoid generalisation but aim to generalise findings and theorise from cases without diverting attention away from the importance of understanding the case itself. This leads me to conclude in these case studies of nurse prescribing I aim to provide

sufficient details for others to generalise if they so wish. To achieve this aim I used Yin's replication logic as part of a sampling strategy.

3.6: Case studies in Nurse Prescribing: Case data.

Yin (1994) presents a strong argument for the use of multiple data collection methods in case study research. He considers the opportunity to gather data from more than one source a major advantage to case study method and, suggests the converging lines of inquiry that may result are more convincing if drawn from several different sources. Yin (1994) identifies six sources of data collection, documentation, archival records, interviews, direct observation, participant observation and physical artefacts. From these suggestions my case studies of nurse prescribing will adopt interviews as the primary method of data collection supported by field notes taken at the time of the interview and attribute data.

Tod (2006) outlines the capacity of interviews to describe, explain and explore issues from the participant perspective and is therefore suited to the purpose of my case studies. For Robson (2002) common distinctions between different types of interview reflect the degree of standardisation and structure imposed on the interview. Denzin (1970) considers unstructured interviews to be the best choice in qualitative studies and he offers three reasons for his views. He believes respondents should talk about their world in their own words. This, he suggests is best achieved without fixed sequencing of questions for two reasons. Because, no single structure is appropriate for all interviews and an unstructured approach allows the interviewer to raise issues outside the schedule. Robson (2002) agrees raising the point that less structure results in a more in-depth interview. I accept the points raised by Denzin and Robson and agree participants should be encouraged to talk about their perspective.

However, I also agree with Hammersley and Atkinson (1983) who suggest, minimal structure is likely to leave the interviewee struggling to interpret what is relevant. Nurse prescribing is a large topic area linked to professional practice and all aspects of working with patients and healthcare professionals. These case studies in nurse prescribing focus on the integration of nurse prescribing. Without some structure there is the potential for the interviews to gather large volumes of interesting data related to nurse prescribing but not sufficiently specific to contribute to answering the research question. There are sufficient findings from the literature review to support the development of an interview schedule and impose some structure. Semi-structured interviews are the most suitable form of interview for these case studies. Semi-structured interviews give the researcher the opportunity to guide the participant to focus on issues relevant to the research whilst at the same time allowing the participants to lead with their own perspective (Gerrish and Lacey 2006).

To capture my views on the interview and the prescribing environment I made brief field notes immediately after each of the interviews. These notes summarise my feelings and perceptions of the interview and note my comments about the interviewee and the practice environment. Yin (1994) supports the use of field notes in case study research suggesting that these notes provide a useful source of additional information about the case. The attribute sheet used at the interview gathered general data about the nurse prescriber. For example attributes such as gender, age, job title, time in post and how long prescribing. The literature review found some of these attributes linked to prescribing activity. I therefore decided to gather this data from case participants in order to investigate their role in determining the integration of nurse prescribing.

The data was organised and managed by manual and computer assisted methods to organise data. The interview transcripts and attribute details were stored in NVivo computer software. A short case summary, prepared for each case and written in advance of data analysis brought together case data from interview transcript, field notes and attribute data. This summary sheet contains main points pertinent to the case and highlights areas I thought were particularly interesting.

3.6.1. case studies in nurse prescribing: interview schedule.

The interview schedule developed from factors identified in the prescribing literature to prevent, hinder or help the integration of nurse prescribing (Lewis –Evans and Jester 2004; Bradley et al., 2005; Courtenay and Carey 2008). These factors reflect three broad areas, prescribing in practice, prescribing in healthcare organisations and education and support. The interview schedule, included in appendix 1, shows how these factors were included in the participant interviews. The factors were incorporated in a set of exploratory questions and organised under three headings. The first section asks general information and records details of the participants nursing role, age and gender on the attribute sheet. The participant experience of prescribing in practice was the focus for discussion in the second section. This set of question explores how the nurse started prescribing and aims to identify any factors that might have influenced prescribing in practice. In recent years, there has been a plethora of standards, guidelines and protocols for practice aimed at improving standards and reducing inequality in healthcare. Guidelines and standards provide systematically developed statements aimed to assist clinical decision making for the treatment and management of specific conditions Flynn and Sinclair (2005). When viewed in this context guidelines standards and protocols can potentially affect the integration of nurse

prescribing and it is therefore important to report how and why nurse prescribers use guidelines and standards in prescribing. The third section explores continuing professional development and support. It explores how the nurse has developed prescribing knowledge and skills since qualification and for the prescriber to reflect on their need for support in the prescribing role.

3.6.2. pilot interviews.

Pilot interviews invited two independent and supplementary nurse prescribers to take part in an interview in their area of prescribing practice. The two invited represent primary and secondary care prescribers. Both nurses had been prescribing for more than two years at the time of interview. Gerrish and Lacey (2006) suggest pilot studies provide a valuable opportunity to see if the proposed interview questions are understandable, relevant and appropriate. I started the first interview by following the interview schedule and began with the opening question 'tell me why you chose to qualify as a prescriber'. I found that it was difficult to follow the schedule as talk developed naturally leading from one set of questions to the next. As the interview continued, I let the questions flow from the participant response. A final check of the schedule towards the end picked up just one question that had not arisen from the interview. At the second pilot interview, I began once again with an opening question, 'tell me what happened once you qualified'. I did not follow the interview schedule but found that all the areas included in the schedule were at some point discussed during the interview. This approach felt comfortable and the pilot interviews gave me a valuable opportunity to practice my interview skills in advance of the formal interviews. The pilot participants gave the sort of response I expected.

In discussion after the interviews, the participants were not able to identify any issues I had missed but which they considered important to the integration of prescribing. The primary care interview lasted for 45 minutes. The secondary care interview ended after 30 minutes. This was a premature end because the emergency bleep was activated and the nurse had to leave.

I did not make amendments to the interview schedule following the pilot interviews. The pilot exercise did confirm that a semi-structured interview approach was appropriate as it allowed the participants to move from one topic area to another in a natural way whilst the researcher was able to control the interview overall (Tod 2002). The pilot participants were able to recount how they started prescribing and had described how prescribing had developed over time. This proved an important point in terms of the study population and sampling schedule. I wanted to capture the experience of nurse prescribers who would be able to describe how they started prescribing. The pilot interviews suggested that prescribing practice develops over time. This is potentially important to understanding the integration of prescribing and therefore the sample should include new nurse prescribers and those qualified for about a year. The fact that one interview was stopped because of a clinical situation raised my awareness as the researcher about being flexible and responsive to clinical situations in the planning and undertaking of interviews.

3.6.3. case studies in nurse prescribing; the study population.

The study population for my case studies comprised of nurse prescribing students who studied and successfully completed the independent and supplementary prescribing course at an East Midlands University. The prescribers included in the study population were all in NHS employment at

the time of the study. Findings from the pilot interviews informed my decision to include nurses who were newly qualified prescribers and nurses who have been qualified to prescribe for just over a year. These timeframes enable new prescribers to describe the integration of prescribing as a recent event and as their experience of prescribing builds. Those prescribing longer would be able to describe changes to prescribing that have occurred over time. I argue that if the integration of prescribing is effective nurses qualified to prescribe for longer will be comfortable with the division of workplace labour and begin to develop prescribing practice. These two factors help to define my research population. I defined the length of time qualified to prescribe for the case study participants at 3-6 months (newly qualified prescriber) and 12 – 18 months (qualified to prescribe for just over a year).

I identified the population for my case studies by preparing a table to help me identify the cohorts of nurse prescribing students who were now qualified and would meet the 3-6 and 12-18 months qualified criteria at the proposed time for interviews. I achieved this by projecting the education and prescribing development times for intakes of nurse prescribing students. Table 3.2 shows this process. The table plots progression dates to ratification of results and included the time taken for the Nursing and Midwifery Council to record the V300 prescribing qualification on the professional register. This is the 'likely to prescribe from date' and I calculated the length of time qualified to prescribe from this date. The highlighted cells in table 3.2 show two intakes of prescribers who meet the 3-6 months, qualified to prescribe, criteria. Two groups also met the, qualified for just over a year and therefore the 12-18 month inclusion criteria.

Table 3.2: Prescribing Groups and projected prescribing time.

Intake	Exam Board	Can prescribe from	3 months	6 months	9 months	12 months	18 months
1 2004	June 2005	Aug 2005	Nov 2005	Feb 2006	May 2006	Aug 2006	Feb 2007
2 2005	Sept 2005	Nov 2005	Feb 2006	May 2006	Aug 2006	Nov 2006	May 2007
3 2005	June 2006	Aug 2006	Nov 2006	Feb 2007	May 2007	Aug 2007	Feb 2008
4 2006	Sept 2006	Nov 2006	Feb 2007	May 2007	Aug 2007	Nov 2007	May 2008
Expected interview period: February 2007 – April 2007.							

The table identifies four intakes of prescribers meet the population criteria at the expected time of interview. The two intake groups for each timeframe had an almost equal number of nurse prescribers. There were 71 nurses qualified to prescribe for 3-6 months from intakes 3 and 4. There were 67 nurses qualified to prescribe for 12 – 18 months from intakes 1 and 2. All the prescribers in the population commenced the V300 independent and supplementary prescribing course after the 1st September 2004 and completed no later than the 30th September 2006. In these timeframes are a total population of 138 qualified nurse prescribers from which a sample was drawn.

A large-scale merger of NHS trusts in early 2007 affected the time plan for this research. At this time, local NHS research and development departments reported delays to research approval because responsibilities had to be re-negotiated internally and, or staffing levels were too low to process approvals. Requests for research and development approval were submitted to five NHS healthcare trusts in January 2007. Approvals were granted between May 2007 and October 2007. It had taken 10 months to secure NHS research and development approval from five NHS trusts. The

delay was unexpected and particularly frustrating because the delays were not a result of problems or concerns about the study proposal. As a direct result of the delay, the timescale for interviews was, put back several months. The delay affected the actual time qualified to prescribe for each of the population groups, which, at the time of interview, was longer than anticipated in the research proposal. The planned 3-6 months and 12-18 months qualified to prescribe became 7-13 months and 14 – 26 months qualified to prescribe. The change has not been detrimental to the study and comparison has remained possible. However, from this point, the timeframes for these case studies of nurse prescribing are 7-13 months and 14-26 months qualified to prescribe.

3.6.4. case studies in nurse prescribing; sample.

These case studies adopt a convenience model of sampling and a table, (Table 3.2) proved a useful tool to identify the population by length of time qualified to prescribe. Using a purposive strategy, I started to identify potential participants using the theoretical propositions of this research as a guide. The sample was drawn from the available population using a non-probability approach (Polit and Beck 2004). In order to answer the research question it was important that the chosen cases represented the variations of role, employer and care setting of nurse prescribers. These variations were the theoretical propositions of the study (Yin 1994). They were also part of the sampling strategy and the data analysis of the case studies. According to Huberman and Miles (2002), case study method can be a useful way to generate theory. To build theory they suggest the case study should adopt a theoretical model of sampling as opposed to relying in statistical reasons for recruitment. Pettigrew (1988), with a degree of pragmatism, comments that given the limited number of cases which can

usually be studied it makes sense to choose cases of extreme situations or polar types in which the subject of interest is transparent and, I agree. The chosen cases should, either, replicate previous cases or extend emergent theory. Yin uses the term replication logic to describe this action, Yin (2003 p45).

Polit and Beck (2004) warn the researcher that because non-probability methods of sampling rarely represent the population they can be problematic. I believe the best way to represent the broad population of nurse prescribers in these case studies is to ensure the sample represents the theoretical propositions of the study.

3.6.5. case studies in nurse prescribing: Yin's Replication Logic.

Replication logic is a term used by Yin to adapt the rigour of empirical research to qualitative case study method. He explains that when a significant finding has resulted from an experiment the goal of empirical research is to try to replicate the finding with further experiments. These should either duplicate the exact conditions or alter experimental conditions, Yin (1994: 2003). His logic for multiple case studies involves the careful selection of cases in order to predict similar results (literal replication) or to produce contrasting results but for predictable reasons (theoretical replication), Yin (2003 p 46). Theoretical replication suggests that any one of the three theoretical propositions used to develop the sampling strategy is likely to influence the integration of nurse prescribing in practice. The literal replicator applies to the cases chosen. This means that these cases share the same role title, employer and work in either primary or secondary care. The sample for this research includes literal replications. There are for example, four practice nurses and two midwives

with the same theoretical propositions. Two thirds of the cases will use theoretical predictors but the sample will also include cases with no literal replication. For example, the participant group includes a mental health nurse and a sexual health specialist nurse. These nurse prescribers share none of the theoretical propositions. The principle of replication logic is important to this case study research because it promotes opportunities for generalisation, Yin (2003). A structured selection process based on a sampling matrix highlights cases that predict similar results (literal replications) or predict contrasting results (theoretical replications), Yin (1994; 2003).

3.6.6. case studies in nurse prescribing: the sampling matrix.

I have chosen to use a sampling matrix to maximise the potential for the sample to reflect the combinations of the theoretical proposition in the total population. The theoretical propositions of these case studies of nurse prescribing are role, employer and care setting. Sampling matrices are, according to Reed, Proctor and Murray (1996) a useful guide to the sampling process because they set out key areas of interest in the study. The sampling matrix designed for this research incorporates three theoretical propositions (Table 3.3). Nursing role is presented in the vertical column and working in primary care, secondary care or both settings horizontally across the top of the table. The third theoretical proposition, the employer is, presented in the font colour of the prescribing nurse's role. For example, two practice nurses have the codes PN1 and PN2. PN1 is, written in the matrix in blue font, as the employer is Primary Care Trust (PCT) A and PN2 in red font for employer PCT - E. There are seven employers each allocated a colour detailed in the legend at the bottom of the matrix. Nurses employed by Hospital Trust - C and Primary

Care Trust - D were geographically disparate and not included in the sample.

Yin (1994; 2003) and Stake (1995) agree that generalisability is important in case study research. I chose to adopt Yin's concepts of literal and theoretical replication. The sampling matrix shows literal replication where more than one nurse prescriber has the same theoretical propositions. These nurses were, employed in the same role, by the same employer and worked in the same care setting. These literal replications reflect the commonality of the role, for example practice nurses. Theoretical replications are easily visible using the matrix as the grid identifies prescribers with different combinations of theoretical proposition. The sampling matrix for one of the four intakes is, shown below in table 3.3 as an example.

The table shows all nurse prescribers for one intake of nurse prescribing students. The nurses who were chosen for invitation are identified in the matrix by the use of bold font and a* next to their name. Healthcare trusts A,B,E,F and G, underlined in the legend, gave research and development approval for these case studies.

Table 3.3: Intake 4: 7-13 months qualified to prescribe.

Nurse	Primary care	Secondary Care	Primary & secondary care. Other
General Nurse	PN1 Practice nurse PN 2 WIC1 Walk in centre WIC 2 PN 3 PN 4 PN 5 PN 6 PN 7 PN 8 *PN9		PRN 1 Prison Nurse PRN 2
Specialist practitioner (NMC)	HV 1 Health Visitor * DN1 District Nurse *CM 4 Community Matron		
Nurse Specialist	NSP 1 Nurse Specialist Sexual health NSP 2 Diabetes NSP 3 Advanced nurse practitioner	NSP 4 :Heart Failure NSP 5: Nephrology NSP6: Urology *NSP7Continenence *NSP 8Colorectal NSP 9 immunology	* NSP 6 Urology.
Mental Health Nurse	MH1 Mental Health MH 2 MH 3	MH 4 MH 5 * MH 6 MH 7	MH 6
Midwife			
Children's Nurse	CN 1 Children's Nurse		CN 1
<p>Primary Care Trust – A Primary Care Trust. - B Hospital Trust. - C Primary Care Trust- D Primary Care Trust -E Mental Health Trust - F Hospital Trust – G</p>			

3.6.7: Case Studies in Nurse Prescribing: Sample.

Yin believes it is important in case study research to ensure the sample size is sufficient to address the research aim (Yin 1994). My research aims

to find out how nurse prescribers integrate nurse prescribing into nursing practice. The theoretical propositions in the sampling matrix (role, primary or secondary care and employer) determine the number of case studies by identifying the point where combinations of theoretical propositions become saturated. The process of identifying nurse prescribers with the same and different theoretical propositions continued until theoretical proposition combinations were exhausted. The number where saturation occurred was 13. The sample for these case studies was 26 cases divided between two groups, 13 qualified to prescribe for 7-13 and 13 qualified to prescribe for 14-26 months.

It was highly unlikely that all of those invited would agree to participate and reserve participants were, identified using the sampling matrix.

Reserve participants matched the theoretical propositions of the case in all but a few cases. Where a match was not available, the reserve matched all propositions except employer. The recruitment of participants took place between June 2007 and November 2007. A table to show the recruitment of participants during this time is, shown in appendix 2. Once recruited new participant codes were, allocated as shown in a table in appendix 11.

3. 7: Case Studies in Nurse Prescribing; Ethical considerations and access.

A research proposal was prepared and internally reviewed in October 2006. The Central Office for Research Ethics Committees (COREC) online process for ethical approval was, completed in December 2006. The research proposal and COREC documents were, presented for approval at the Southern Derbyshire Research Ethics Committee meeting in January 2007. The committee required the following minor amendments:-

1. The consent form format was not in the preferred style and required amendment.
2. The committee noted that the research did not include observation or analysis of patient interaction or nursing practice. However, there remained potential for the unlikely situation of the researcher identifying practice considered a risk to patient and public safety. In this situation, the committee felt it important that participants were made aware that the researcher would act within the Nursing and Midwifery Council Code of Professional Conduct and Ethics (2008).
3. The participant information sheet required amendment to include a statement to address action in the event of unsafe practice. This statement was, added to the participant information sheet at the request of the committee (appendix 3).

The Southern Derbyshire Research ethics Committee gave a favourable ethical approval in February 2007. Applications for NHS research and development approval were, sent in January 2007. One primary care trust NHS research and development department had responsibility for approvals in two primary care trusts therefore four applications for approval were, sent to recruit participants from five NHS Trusts.

- Primary Care Trust A
 - Primary Care Trust B
 - Primary Care Trust E
 - Mental Health Trust F
 - Hospital Acute Trust G
- } Joint application for NHS research
and development approval.

3.8: Case studies in nurse prescribing; informal access negotiations.

Access to conduct research in the case environment is an important feature of case study method (Stake 1995; Gerrish and Lacey 2006). To achieve the variation of theoretical propositions described in the research proposal NHS research and development approval was required for five healthcare areas representing primary and secondary healthcare services. I have been teaching nurse prescribing to practitioners from these areas for ten years and I drew upon existing professional relationships with prescribing leads within these organisations to assist access negotiations where necessary. There were some initial difficulties gaining access to interview participants in secondary care settings. The large-scale merger of local healthcare trusts was, at the time leading to redundancy for some nursing staff. Those who remained in post were under management instruction not to take part in any non-patient work. Participants offered to take part in interviews their own time either before or at the end of a shift. As discussed in a previous section, staffing issues in research and development departments delayed approval and subsequently the start of data collection.

I applied university regulations for data protection throughout this research. Reflecting good research practice electronic data was stored on a password protected computer and paper copies of transcripts secured in locked drawers. The code sheet links the participant names to the participant codes. Only I have access to this document, which is stored in a secure location away from the data (Gerrish and Lacey 2006). All research data from these case studies is stored electronically on a secure university server. This data will remain on the server for a maximum of 7 years to commence from January 2007 when the research began.

3.9: Case studies in nurse prescribing; participant invitation.

Participant information letters were, sent by post. The letter, sent to their home address gave details of the study and invited the prescriber to respond by returning the enclosed slip or by email if preferred. The participant invitation letter can be found in, appendix 4. A second letter sent 14 days later gave those who had not responded a further opportunity to take part. Where two letters failed to recruit, I sent a letter inviting a reserve participant to take part and repeated the process until 26 case participants were, recruited. Delayed approval from NHS research and development moved the interview period from spring to summer.

Recruitment was very slow during July, August and early September due to the summer holidays but improved at the end of the holiday period. A table in appendix 2 details the recruitment process. It was particularly difficult to recruit from secondary care. 18 invitations were sent and only 4 participants recruited. This is a marked contrast to primary care where I recruited 20 participants from 37 invitations. It is important here to note, that at the time when the invitations were, sent there were major concerns about job security for hospital nurses in the study population area. Those in senior and specialist positions were most at risk and nurses holding these positions were often prescribers. This helps to explain in part the difficulties I encountered when recruiting from secondary care.

3.10: Case studies in nurse prescribing; data collection.

As the chief investigator for this research, I invited participants, arranged interviews, conducted interviews and transcribed them. I made contact with the participant by telephone or email on the working day prior to the planned interview and confirmed the arrangements remained convenient. Interviews were, conducted in the participant's clinical area and a brief

description of the clinical environment recorded in field notes. The notes were, written up immediately after the interview. I was conscious not to put the practitioner under any pressure in terms of unnecessarily using clinical time. I always arrived early and allowed several hours for the interview. Interviews lasted between 45 and 75 minutes. On several occasions the participants clinic finished late and the interviews commenced much later than expected, on two occasions a participant cancelled the interview on the day and one participant cancelled as I arrived. I reassured participants that patients must come first and the interviews took place on another day.

When I attended the participants practice area, I checked that the participant had received the participant information sheet. I answered questions about the study, thanked participants for taking part and invited the participant to sign the consent form. Copies of the participant information sheet and consent form are included in appendix 5 and 6 respectively).

At the start of the interview, I asked if the participant had read the participant information sheet and invited them to ask questions about the research or interview process. Immediately prior to the interview, I invited the participant to read and if in agreement to sign the consent form (appendix 6). Attribute data and field notes gathered at the time of interview were, used during analysis to corroborate interview data (Yin 1994). I completed the attribute sheet at the beginning of the interview. It was not necessary to collect copies of the guidelines and standards identified by participants on the attribute sheet. These documents were, freely available in the public domain and scrutiny of the content of these guidelines was not necessary. I recorded the interviews on a digital audio

recording device. Reflecting after the first two interviews, I identified that participants were continuing to talk after the interview had formally ended. This had not occurred in the pilot interviews. With the consent of participants, gained at the beginning of the interview, the device was left recording until I left the room to capture any final comments.

3.10.1: Case studies in nurse prescribing: reflexivity.

Polit and Beck (2004) state simply that reflexivity refers to the researcher's awareness of themselves as part of the data they are collecting. Patton is more directive stating that reflexivity "reminds the researcher to be attentive to and conscious of the cultural, political, social, linguistic and ideological origins of ones own perspective as well as the perspective and voices of those one interviews and those to whom one reports", Patton (2002 p65). His statement identifies the challenge of reflexivity in these case studies of nurse prescribing.

The main issue in terms of reflexivity in these case studies comes from my existing relationship with participants, and my knowledge of the legal and professional framework of non-medical prescribing. As an insider to the research, I share knowledge of the clinical environment and principles of nurse prescribing in practice with my participants. In addition, I bring to the research an honest interest in the research subject and a desire to hear about integration from the prescriber perspective. The existing relationship was a positive influence on the research. My participants accepted me into their workplace, where I was able to gain some experience of the clinical environment in which prescribing is integrated. Participants trusted me to understand what they were saying in the interview and to report their views accurately. This form of insider relationship can, according to McNair, Taft and Hegarty (2008) encourage research participation and allow

exploration of sensitive issues such as prescribing in interviews. It is likely that knowing the participants encouraged some to get involved but may have discouraged others.

Insiders to research can have negative as well as positive effects on the study although according to McNair et al. (2008) the negative impact of insider research is less well recognised. The negatives are almost polar opposites of the positives already presented. The most obvious question to ask of myself is that, if I know the participants am I the right person to be undertaking the research. The existing relationship might lead participants to speak about what they think I want to hear rather than express their own views and opinions. Some may wish to make a comment they know I would disagree with and they then might question if I will include or accurately report their view.

From my extensive knowledge of the legal and professional framework of non medical prescribing, I have a clear understanding of safe, accountable and legal nurse prescribing in practice. Patton (2002) suggests being reflexive requires an ongoing examination of what I know and how I know it. My answer is that this knowledge has developed out of my role as lecturer in non medical prescribing and it is an expectation from nurses, employers and professional bodies that I have this knowledge. In my lecturing role, I have taught and assessed all nurse prescribers in the sample population. I know in detail what the participants were taught on the nurse prescribing, course and I know that at the point of qualification they were assessed to have a level of knowledge and understanding consistent with that required to be awarded a prescribing qualification. This situation means that as the researcher I had expectations that the participants would be prescribing within legal and professional frameworks

of independent and supplementary prescribing. Prescribers invited to take part in the study and those who did take part were aware of my role. A student, teacher relationship had existed between us.

According to Polit and Beck (2004) researchers must be conscious of the part they play in their own study, reflect on their own behaviour and consider how it can affect the data they obtain. The situation described above presents several potential issues that might have affected both the participant decision to take part in the study and the data collected. It is important therefore that as the researcher I act consciously to address reflexivity. I could have chosen to limit the insider affect on my research by inviting prescribers who I had not taught.

Throughout the prescribing course, students are aware that practice considered by the examiner to be actually or potentially unsafe will result in a fail regardless of mark achieved. In response to the Southern Derbyshire Research Ethics Committee, application for ethical approval the study consent form included a statement indicating that the employer and the NMC would be, informed upon the event of unsafe prescribing practice (appendix3). In ethical terms, the approach is both appropriate and necessary for research into this area of nursing practice. It was important that participants were, given this information so that they could make an informed decision whether or not to take part. The participant information sheet provided this information. The consent form ensured those who were happy to take part received adequate information prior to giving consent to participate. It would have not been ethical to omit this point from the consent form or participant information sheet. However, awareness of this potential outcome of taking part may have discouraged some potential respondents.

Following the extensive and rigorous programme of prescribing education, that the participants and I had been a part of there is an expectation on my part that the prescriber is prescribing for patients in practice. I am however aware from the literature that studies had reported some qualified to prescribe choose not to prescribe. I was genuinely interested to find out why this might be and in addition conscious that those not prescribing might decide not to take part. The participant invitation letter included a statement specifically inviting non-prescribers to take part.

The interview schedule made no distinction between independent and supplementary prescribing however, the terms were in use throughout the interview. In light of their successful completion of prescribing education, I felt it was reasonable to expect that the participants had some knowledge and understanding of the difference between independent and supplementary prescribing. There were a small number of occasions where it became obvious to me that the participant did not fully understand the terms. On these occasions, I was careful to consider the participants response in two ways. Firstly, to consider if the prescribing practice described were in any way unsafe or potentially unsafe. Secondly, I made a note of the misunderstanding in the field notes to aid analysis. Where this occurred the participants asked for clarification of independent and supplementary prescribing during the interview.

According to Flick (2006) the subjectivity of the researcher and of those being studied becomes part of the field. Their impressions, feelings and so on, become data in their own right forming part of the interpretation. I incorporated this form of reflexivity in my data collection and stages of data analysis. Field notes were the chosen method used to capture these impressions and were an integral part of the later stages of data analysis.

It was not my intention to undertake any interpretation of the data at the first stages of analysis. My interpretation has an important role in the development of themes as McGhee, Marland, Atkinson (2007) suggest, these must be inductively derived from the data and field notes.

3.11: Case studies in nurse prescribing; preparing the data for analysis.

My case study data was organised using NVivo 7 computer software, and analysed by manual and computer assisted analysis of data. In preparation for analysis, the case data was first prepared and later uploaded into NVivo.

3.11.1. interview transcripts.

Each interview transcript was, transcribed verbatim from a digital audio recording transferred to the computer. Punctuation was not, imposed on the text but inserted where obvious and grammar and colloquial terms transcribed as they were, spoken. Diction signs were used only to show where the participant was thinking, had stopped mid sentence or paused then continued to speak. These are indicated in the text by a series of 3 or more full stops. To aid clarity headings were, added to the transcription to indicate the speech of facilitator and participant. These headings were subject to formatting with heading styles to assist later coding in NVivo (Bazeley 2007).

3.11.2. attribute data.

Attribute data is described as "the information which is known about the case but not mentioned in the course of conversation" (Bazeley 2007 p 135). Attribute details were gathered at the beginning of the interview and recorded on an attribute sheet. The summary of data can be seen on an

excel spreadsheet in appendix 7. The sheet is a record of participant details such as gender, age group, employment in primary or secondary care, role title, time in post, prescribing intake group, able to prescribe from and month started prescribing. The data from each sheet was transferred into an Excel spread sheet and uploaded into NVivo at case node level. Storing the data at this level enables the researcher to run queries about the attributes at single and cross case levels. For example, Courtenay and Carey et al. (2007a) suggest prescribing confidence is greater in older nurse prescribers. Using attribute data, I was able to run a query and explore this suggestion with my own data. In order to provide myself with a detailed summary of this data I developed a summary of case data sheet (appendix 10). Using this summary sheet, I was able to quickly, identify group specific details. For example, the summary sheet shows there were 2 participants not prescribing from intake 3, 1 participant not prescribing in intake 1 and 2 but all participants from intake 4 were prescribing.

3.11.3. case summaries.

Stake (1995) recommends that case study researchers draw case data together in the form of a report or summary. The reports described by Huberman and Miles (2002) and Yin (1994; 2003) are detailed and in-depth. This sort of case report is well suited to case studies with vast amounts of data. These nurse prescribing case studies produced a large but manageable amount of data. Taking into consideration the purpose of the research and the data, I decided to adopt the case summary approach suggested by Mason (2002). These summaries bring the main findings of the data together in a brief reflexive case account. The approach allowed me as the researcher to identify what the prescriber was saying whilst allowing me to think about my own role in the generation of the data. The case summaries are included as data for the manual analysis of case data.

Case summaries of the 9 illustration cases presented in chapter 4 are included in Appendix 9.

3.12: Case studies in nurse prescribing; data analysis.

Plan of analysis

The case data was analysed in four stages using computer assisted and manual methods of data analysis. The first stages of data analysis set out to reduce the amount of data using a content analysis approach (Patton 2002; Clarke and Reed 2006). The method aims to reduce data volume and identify core consistencies and meanings from the data. Computer assisted analysis dominate the first two stages of analysis. The latter two stages used manual methods for single and cross case analysis with reference to published research.

Four stages of data analysis.

Stage 1 :

- Computer assisted organisation and analysis to create free nodes from interview data.
- Computer assisted and manual analysis of case data to organise free nodes into sibling nodes and reduce data to tree nodes.

Stage 2:

- Manual and computer assisted analysis of tree nodes and case data to identify themes.

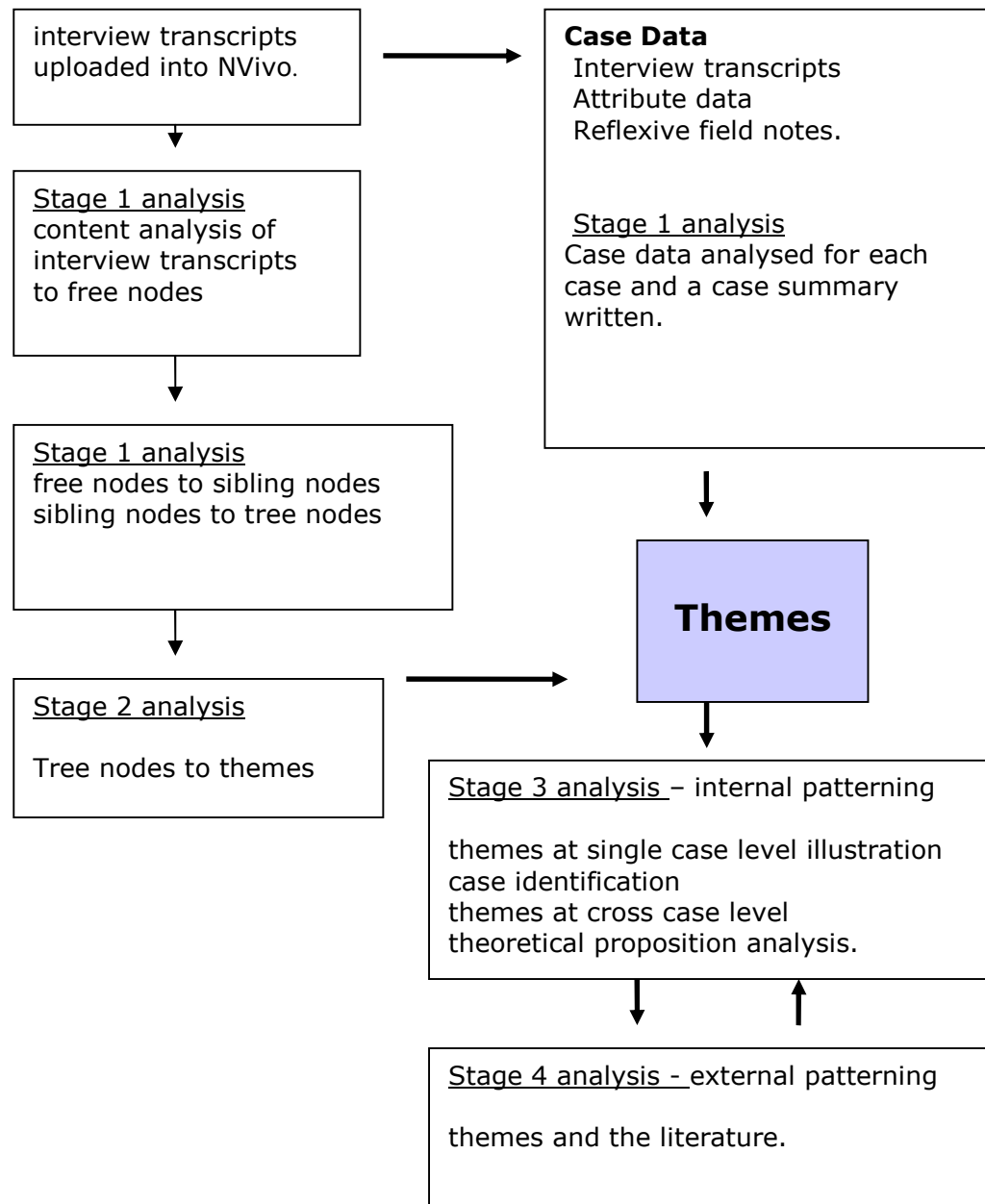
Stage 3 :

- Manual analysis of data at single and cross case levels to confirm patterns and themes.

Stage 4 :

- Manual and computer assisted analysis of data in relation to external knowledge generated by other research consistent with the literature review and justification for study

Figure 3.1: Diagrammatic representation of data analysis.



3.13: Stage 1 analysis: Computer assisted and manual analysis of interview data in NVivo to create free, sibling and tree nodes.

Stage 1; transcript data to free nodes.

I began by reading each interview transcript in full to familiarise myself with the interview data. Mason (2002) describes this as literal reading and

goes onto describe two further forms of reading, interpretive and reflexive. The alternative forms she describes require the researcher to make a judgement about what a participant is saying and to impose codes on the data, Mason (2002). The transcripts created a wealth of raw data, which needed to be categorised and organised (Patton 2002). I chose to use NVivo to assist this process. The software facilitates the analysis of case data by helping to manage and order, interview and attribute data. In this first stage of data analysis, I chose a simple descriptive approach to data coding. Bazeley (2007) describes different ways of coding ranging from simple descriptive codes to the interpretation of data and imposition of interpretative codes. My decision to adopt a descriptive approach draws on findings from the non-medical prescribing literature. The literature review identified several factors said to promote, hinder, or prevent nurse prescribing. It would be possible to impose the factors as themes and code the case study data around each theme. This approach would however be likely to negate the opportunity to identify new factors or small nuances emerging from the data.

Free nodes are the basic level of NVivo coding and the software stores, in alphabetical order, the titles assigned by the researcher to each code. The analysis began by coding the full content of each interview transcript sentence by sentence. Each code represents a description of what the participant is talking about in that particular sentence or section. In this example from the case studies, a participant described how she first started prescribing for patients who presented at the minor illness clinic. This sentence was allocated the code 'how I started prescribing'. Particular care was, taken throughout the allocation to include surrounding sentences where necessary to protect meaning and reduce the potential for misrepresentation. There were several occasions where a sentence covered

more than one topic. Two codes were allocated to the sentence and the coding refined later at sibling node level.

On completion of this first stage of coding NVivo organised the interview data in two forms. In the first, as complete interview transcript and second as a series of excerpts presented alphabetically under descriptive free node headings. NVivo helps the researcher to manage coded data by creating a reference for each excerpt. The software is able to locate and retrieve the excerpt when required, Bazeley (2007). From 26 interview transcripts, 217 descriptive codes were identified and stored in NVivo at free node level.

3.13.1. Stage 1 analysis of transcript data: collapsing free nodes to create sibling nodes.

The next activity in stage 1 analysis was to refine and collapse this large number of free nodes and organise them into sibling nodes. Free nodes are as their name suggests not attached to a particular topic or concept. Sibling nodes are a group of free nodes that focus on or talk about a particular concept from the data. The sibling nodes emerged from free nodes through the manual analysis of data. I began by reading the excerpt (s) for each free node and found many were similar. These free nodes represent or talk about the same things or, as Bazeley describes, they “hang together”, Bazeley (2007 p99). These obvious groupings were brought together to create sibling nodes. This stage of analysis combined 217 free nodes into 12 sibling nodes.

3.13.2. Stage 1 analysis of transcript data; redefining sibling nodes to create tree nodes.

The final part of stage 1 analysis sees the sibling nodes collapsed and refined once more to develop a small manageable number of tree nodes.

Although the tree nodes are organised and stored in NVivo, manual methods were the primary method of analysis. Free and sibling nodes emerged from the interview transcript data. Tree nodes are different because they develop from the whole data for the case including interview transcripts as opposed to interview data alone. The analysis began with sibling node excerpts of interview transcripts. These were located in, and retrieved from NVivo. The printed excerpts for each sibling were then organised under the 12 sibling node headings in sections within a large lever arch file. Each excerpt was subject to repeated reading using an interpretive and reflexive reading technique (Mason 2002). Interpretive reading encourages the creation of tree nodes by focussing on what the data is saying about a particular topic. Reflexive reading was particularly important at this point of analysis because there were occasions during the interview when the participant asked for an explanation of something directly related to prescribing. Where this occurred, it was important that the analysis reflected the participants understanding of independent and supplementary prescribing. This form of reading used at this stage of analysis helped me to develop tree nodes that were a reflection of my thoughts about what the data was likely to mean.

It was at this stage of analysis that the choice of case study design began to cause some tensions. NVivo had proved a very effective way to identify what participants were speaking about during the interviews. In terms of the exploratory and descriptive aim of these case studies, it was important to identify all participant contributions. NVivo enabled me to set some order to this process and to manage what was a considerable volume of interview data. Having reached this stage, I found the method of analysis moving the focus away from the single case. I had not used NVivo software to analyse the case data as a whole. Having considered the

problem I continued my analysis, at this stage adopting a manual analysis of all case data. The case data comprised of, interview transcripts, field notes and attribute data. Analysis was undertaken using reflexive reading at single case level. Each piece of data was read at least twice and a brief case summary written (Mason 2002). As I analysed each case it became apparent that there were several strong themes emerging from the quintain of case studies. I returned to the interview data in order to establish if themes emerging from the whole case data were those reflected in the interview data.

Using mind maps, I began by grouping sibling nodes under descriptive headings. For example, several case participants said they felt anxious about taking accountability for independent prescribing. Other participants talked about how extensions to the legal framework of independent prescribing left them feeling overwhelmed. In this way connections between the concepts emerged and sibling groups fell logically together to form 6 tree nodes.

The final tree node groupings were, entered into NVivo. This facility organised the data and enabled the analysis of attribute data in a later stage of analysis. Each tree node represents a topic area the participants spoke about and I imposed a loose hierarchy on the data in NVivo to identify the most popular topic areas. According to Bazeley (2007) the facility of NVivo facility to organise data is an advantage to using the software. It was not the aim of this research to identify factors in a hierarchy of importance or, to create a classification system of factors. The facility was however, a useful tool to organise tree nodes by strength of participant response. The topics talked about by the majority of participants appear higher in the table. In table, 3.4 tree nodes in the right

hand column are organised in a loose hierarchy determined by the frequency of participant response.

Table 3.4: Table showing stage 1 analysis using NVivo: sibling and tree nodes.

	Sibling Node	Tree Node
1	Respect and Trust between nurse and doctor, nurse and employer.	The relationship between nurse prescriber, doctor, nursing team and employer.
2	Accountability and responsibility of prescribing, legal and professional	Legal restrictions and professional expectations of nurse prescribers
3	Types of prescribing; Independent & Supplementary prescribing	
4	Personal approach to and boundaries of prescribing.	
5	Taking on medical roles	
6	The acceptability of nurse prescribers in healthcare teams.	Defining the prescribing role and the changing division of labour.
7	Enhancing roles enhancing care.	Prescribing enhances nursing practice.
8	improved patient outcomes resulting from nurse prescribing.	
9	Employing organisation; support, facilitation and restriction	Employers control of prescribing
10	Changing professional assessment; competence and confidence.	Prescribing knowledge
11	Using guidelines and standards to prescribe.	
12	Prescribing knowledge and continuing professional development	

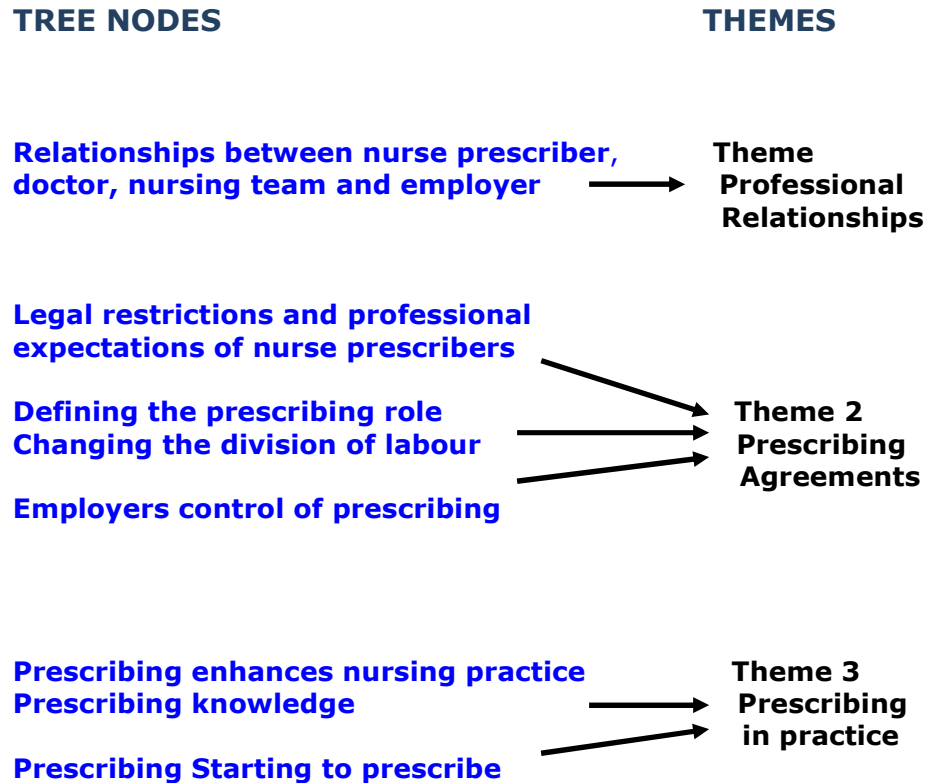
3.14: Stage 2 analysis: manual analysis of tree nodes to identify themes.

Stage 2: identifying themes from tree nodes.

I began the analysis by studying the mind maps and reading the interview transcripts again. The aim, to reacquaint myself with the interview data at single case and tree node levels in order to confirm that the patterns and themes I had found were present. Yin (1994) and Robson (2002) support these actions in case study research. The tensions identified in stage 1 analysis between analysis at single case level and themes emerging from the data as a whole had not been resolved. I gave this considerable thought consulting again the work of Yin and Stake. I read again, each case summary and explored the mind maps developed from case data. It was obvious that the emerging themes were strong, and as such outweighed the contribution of single cases. My decision creates a form of hybrid case study. Setting my case studies apart from the methodological rigour Yin recommends case study researchers should follow, Yin (2003). However, the themes came through the data with such strength that breaking them down and presenting the findings in single cases would I felt, loose some of this strength. Therefore, while cases were, presented as data they developed through a form of thematic analysis into themes. Findings from single and multiple cases is were to illustrate theme findings

Three themes, professional relationships, prescribing agreements and prescribing in practice emerged as participants described their prescribing experiences. Each theme identified factors described by participants and reported in the prescribing literature to promote, prevent or hinder the integration of prescribing in nursing practice. The process of developing themes from tree nodes is, shown in Figure 3.2.

Figure 3.2: Diagram showing connections and the development of themes.



3.15: Stage 3 Analysis: Manual analysis of case data using theoretical propositions to confirm patterns and themes at single and cross case level.

Stage 3 analysis using theoretical propositions.

This third stage of analysis draws on Yin’s preferred strategy of case study analysis (Yin 1994). Cases were analysed individually and then comparatively based on a pre- determined set of theoretical propositions. These case studies used three theoretical propositions, employer, role and primary or secondary care. The propositions were important because

individually and in combination they represent factors found in the non-medical prescribing literature to affect nurse prescribing in practice. These factors have a central role in the sampling strategy and form part of this stage of single and cross case analysis in the quintain. Participants in the study shared common characteristics, employer or role for example. It is useful here to remind ourselves, that Stake describes a collection of cases sharing common characteristics as a 'quintain', Stake (2005 p6).

The analysis began at single case level, reading case data and reviewing content in terms of factors affecting the integration of prescribing and the three theoretical propositions. The theoretical propositions were analysed first by reading. This process identified cases where the participant spoke about one or more of the propositions. Theoretical propositions were analysed at single and cross case levels to see how effectively they might predict the integration of prescribing. An important part of the sampling strategy was length of time prescribing. The participants represent two groups of prescribing nurses. The first were relatively new prescribers and the second had been qualified to prescribe for more than a year. The length of time prescribing is included in single and cross case analysis and its influence on the integration of prescribing considered.

3.15.1 Stage 3. internal patterning, the manual analysis of data a single and cross case level.

As Gerrish and Lacey (2006) predict internal patterns began to emerge at a single case level. These patterns reflect the three themes developed from stage 1 and 2 analysis. The three themes are professional relationships, prescribing agreements and prescribing in practice. Case data was, read in full in order to confirm the internal patterns and themes, which emerged.

Case summaries provided a quick reference from which illustration cases were drawn. According to Stake (1995), illustration cases can help to explain key findings from the data. The choice of case was important and each case identified serves to illustrate in detail one of the study findings. They are a useful way to both explore and gain understanding from the nurse prescriber perspective. There are 10 illustration cases included in the findings and discussion chapter. These cases primarily illustrate main findings for each theme using single case data. Stake (1995) suggests searching for themes across a number of cases is a useful way to refine understanding of a particular issue. In this way cross case analysis identified similarities and differences between cases and groups of cases in the quintain.

3.16 : Stage 4 analysis: analysis in relation to external knowledge generated by other research consistent with the literature review and justification for study.

In this fourth and final stage of analysis themes developed from the data were explored with reference to the prescribing literature. Gerrish and Lacey (2006) suggest case researchers should follow internal pattern analysis, completed here in stage 3 analysis, with external patterning. The literature review and justification for study provide the basis for external patterning as explanations described in single and cross case analysis are analysed in context of knowledge generated by previous research. The literature review identified several factors found to prevent, hinder or promote nurse prescribing. These factors, identified in the prescribing literature are included in the three themes to emerge from data analysis in stages 1-3. Other conclusions drawn from the literature, the affect of age on prescribing confidence, Courtenay and Carey et al.(2007a), for example

were analysed against free, sibling and tree node data in NVivo using attribute data uploaded at stage 2 analysis.

One key point from the literature to influence this stage of analysis is the year of research in relation to the chronological extension of independent nurse prescribing. My case studies were, conducted after, the independent prescribing formulary opened in May 2006 most prescribing research takes place before this date. This point is important because the extension of independent prescribing in 2006 affects both the legal framework and the autonomy of nurse prescribing. This key point is subject to discussion in chapter 4, with reference to findings from these case studies.

3.17: Case Studies in Nurse Prescribing; Chapter Summary.

This chapter aims to show how I investigated the integration of nurse prescribing in primary and secondary care nursing. The primary factor influencing the choice of method and research design was my intention to focus on the nurse prescriber in clinical practice. The prescribing literature identifies several factors reported to prevent, hinder or promote nurse prescribing. These alone are not sufficiently detailed to explain why some nurses prescribe whilst others choose not to and to explain variation in their approach to prescribing integration. Situating the nurse prescriber as the case at the centre of these case studies is an attempt to identify and gather details of the factors that influence integration from the perspective of the prescriber.

Following an exploration of research tradition and method, qualitative case studies emerged as the most appropriate research method to answer my research question. My case study design draws on the work of two leading

authors of case study research, Stake and Yin. Their favoured designs develop along different but complementary approaches. I took elements from each to tailor the design of this quintain case study of nurse prescribing. Stake (2005) uses the term 'quintain' to describe a collection of cases all of which share a set of common characteristics. In this case study design each nurse prescriber shares two common characteristics with all cases, those of profession and prescriber. In addition other common characteristics, for example those of role and employer, are shared with one or more of the cases. The factors applied as theoretical propositions were a useful way to identify and gather relevant information from cases (Yin 1994). The propositions played an important role in 'bounding' the case (Stake 1995). Unbound cases lead the researcher to gather a large amount of data about the case, which is not helpful to the research question and would have been likely to create unmanageable volumes of data (Yin 2003). The sampling strategy took account of the theoretical propositions of role, employer, primary and secondary care and length of time prescribing. This strategy identified a saturation of theoretical propositions at 13 cases for one timeframe. In order to reflect both timeframes equally these case studies of the integration of nurse prescribing comprise of 26 cases, 13 from each timeframe (7-13 months, 14-26 months qualified to prescribe).

Interviews were the primary source of data collection and supported by attribute data including a document record, field notes and a case summary. In a four-stage process of computer assisted and manual analysis, the case data was subject to content analysis, single case analysis, cross case analysis and finally analysis with reference to the prescribing literature. Manual methods formed the primary method of analysis. Whilst computer methods were useful for organising the content

analysis of interview data I found the structure they imposed began to draw focus away from the nurse prescriber and towards the themes. The nurse prescriber is the focus for these case studies and the central focus was, established by manual analysis of case data and illustration cases (Stake 2003), to illustrate themes.

CHAPTER 4: FINDINGS AND DISCUSSION.

4: Research aims and objectives.

Before findings are presented let us remind ourselves of the research question, argument and objectives. The research question asks 'how do nurses integrate prescribing into primary and secondary care practice'? The focus on integration develops from the premise that the word integration means to combine and accept. In the context of my case studies the integration of prescribing into practice is the process by which a nurse prescriber combines prescribing skills and knowledge with nursing skills and knowledge to prescribe for patients. To be effective any integration of prescribing must be consistent with the legal framework of nurse prescribing and, be acceptable to the nurse, employer, patient and the healthcare team.

Four objectives guide this research.

- describe the methods of integration
- identify and explore factors from the nurses' perspective that determine if and how prescribing will be integrated.
- identify through case studies the effect length of time qualified to prescribe has on the integration of nurse prescribing in practice.
- contribute to the evaluation and development of prescribing education by description and analysis of integration during the consolidation of prescribing

The integration of prescribing in primary and secondary care must be implemented within the legal framework of prescribing defined by the Department of Health, DH (2005); DH (2006) and professional standards of prescribing determined by the Nursing and Midwifery Council, NMC

(2006). These systems form the legal and professional frameworks within which nurse prescribing in England must be practiced.

I present my findings in three themes, prescribing agreements, professional relationships and prescribing in practice. Figure 3.2 shows there are three themes to emerge from six tree nodes. I present the themes separately however; there are occasions when the themes interrelate. These interrelations are subject to discussion in the theme where they arise. The findings from these case studies of nurse prescribing are presented under theme headings and discussed with reference to the literature and related theory. Throughout excerpts from participant interviews are included and explored with reference to the literature. Where a more detailed examination of findings is necessary excerpts from single case interviews are included. These 'illustration cases' are presented with case data summaries to add context and case specific information to the discussion (Appendix 9).

4.1: THEME 1: PRESCRIBING AGREEMENTS.

4.1.1. Prescribing Agreements: new jurisdiction for prescribing.

In chapter 2, I discussed the claim by nursing for jurisdiction over prescribing. It is useful however, at this point to remind ourselves that the claim for jurisdiction of prescribing was successful because prescribing policy became part of the political initiative to modernise the NHS. Nurse prescribers have an important role in improving access for public and patients to NHS services especially in areas where medical cover is limited. The principles of non-medical prescribing are set out in legislation and agreed by the professions and regulatory bodies; General Medical Council, Royal Pharmaceutical Society of Great Britain, Health Professions Council,

and the Nursing and Midwifery Council. These agreements formally change the jurisdiction of medicine and the non-medical prescribing professions.

Abbott defines jurisdiction as “the link between a profession and its work”, Abbott (1988 p 20). He argues that in order to establish the authority to control its work an occupation must claim and maintain jurisdiction over that work. As determined by the 1968 Medicines Act, doctors have shared jurisdiction for prescribing with dentists and vets. The addition of prescribing first, to the role of the nurse and later, to pharmacists and allied health professionals extends this shared jurisdiction. Unlike dentists and vets, these new groups of prescriber share the workplace of doctors and jurisdictional boundaries move. The addition of prescribing changes the boundaries of jurisdiction between nursing, medicine, and in addition, those of nursing with other healthcare professions such as pharmacy and physiotherapy. Abbott argued that in the system of professions “one cannot examine external effects without also examining the internal dynamics which they disturb” Abbott (1988 p 35).

By sharing prescribing rights medical dominance over prescribing is challenged and a new division of labour must be agreed in the workplace. In these excerpts, participants recognise how, as prescribers they are working outside the boundaries of traditional nursing practice. At interview participants were asked to describe how they felt about taking on the previously medical role of prescribing.

“ I think for me it is not replacing the GP role it is about complementing it”.NSP1 Page 7.

“ I don't think we are going to replace doctors there is no role for us to replace. I am enhancing the service not replacing the GP”. WIC2 Page 10.

" we are maxi nurses not mini doctors, nurses will always have a holistic approach and I think that is the difference". WIC1 Page 10 .

"I do consider myself to be a nurse, colleagues ask why didn't you go and do your doctor training? Because I am a nurse and I don't want doctor training, just because I am prescribing in my speciality" NSP5 page 8.

In their response the participants choose to highlight the differences between medical and nursing roles. May and Fleming (1997) also found nurses were more concerned about constructing differences between doctors and nurses than they were competing for territory. Jurisdiction to prescribe was not, used by my participants to compete, to replace professions or to threaten hierarchies within the division of labour. Instead, the focus was on sharing prescribing authority to the benefit of doctor, nurse and patient. This approach maintains the legitimacy of gender composition that has, according to Witz (2002), shaped inter-occupational dominance and subservience.

Moving into the jurisdiction of medicine, the acquisition of prescribing rights does mean that nurses need some knowledge previously held in the domain of medicine. This knowledge of clinical diagnosis and pharmacology formally moves nursing towards cure philosophies associated with medicine. Witz (2002) suggests, where nurses enhance their sphere of practice with 'curative' actions they take an independent path to developing the nursing profession itself, Witz (2002 p 31). She suggests the curative route is a dependent path paved for nurses by medicine. In terms of prescribing this appears to be so, as nurse prescribers must acquire prescribing knowledge held by medicine.

Bradley et al. (2005) had found that nurse prescribers were not concerned with prescribing replacing other caring skills in their roles and concluded that prescribing does not create a conflict between care and cure roles. Nurses in a study by Pearcey (2007) also showed little concern for taking on additional technical activities. Her participants did however express regret that patients might be losing out as nurses spend less time on caring tasks. It is possible that prescribing roles go some way to redress this balance because the activity requires the nurse to spend time with patients.

Prescribing by proxy and the supply of medicines by patient group direction (DH 2000b) were precursors to the change in prescribing authority. My participants are clear in their responses. As nurse prescribers they identify their status as nurses who prescribe, not doctors, not mini doctors or there to replace doctors. Participants willingly accept and integrate a cure philosophy in their nursing roles. Baumann, Deber, Silverman et al.(1988) point out that care and cure roles are written about in the literature as mutually exclusive but argue that they are instead end points of a continuum. According to their approach, healthcare professionals adopt different models of care / cure combination to reflect the clinical circumstances of the patient rather than professional boundaries of clinical practice, Baumann et al. (1988). A nurse prescriber is therefore likely to work with a greater emphasis on cure than a non-nurse prescriber but all nurses are involved in some cure activities.

New boundaries of jurisdiction allow nurses and other non medical prescribers the legal and professional authority to prescribe for their patients. In order for this change to the ties of jurisdiction (the tasks associated with the role of the profession) to occur, a new division of

labour must be agreed. In terms of jurisdictional ties, the acquisition of prescribing rights by nurses is not consistent with the traditional public image of nursing or the previous legal restrictions of nursing practice. However, at interview my study participants spoke about the change to jurisdictional boundaries suggesting that these were neither unexpected nor unacceptable to patients, doctors or themselves, as these examples from secondary and primary care show,

" We used to advise the doctor what drugs to prescribe anyway so it is just actually writing the prescription" NSP5 Page 8.

" the doctor would then just sign the slip on whatever I had told him to prescribe without often coming down to see the child and then I was carrying on "CN1 Page 1

"prescribing was sort of the icing on the cake for me because really I have been prescribing without a prescription for the last 10 years" PN5 Page 2.

" I think doctors have been slowly letting go and trusting us with more things and I think it is just an extension of that really, it just feels natural" PN7 Page 10.

Being able to prescribe is, to my participants, a logical step forward in their professional development and they welcome this addition to their role. Most participants described how they had been prescribing by proxy and advising doctors about prescribing before they came to prescribing education. From this position independent and supplementary prescribing was seen as a natural addition to their role. Prescribing provides the nurse the autonomy to complete episodes of care. Participants report that being able to do this enhanced their nursing role and increased job satisfaction. These findings will be discussed in more detail later in theme 3, prescribing in practice.

Considered in this context the claim for jurisdiction of prescribing by nurses does not represent a major change to the role of the nurse or nursing practice. The stance is reflected in the historical development of nurse prescribing. Baroness Cumberledge recognised in her report that nurses were already making prescribing decisions, DHSS (1986). Those involved in the 1990's claim to secure prescribing rights for nurses used this argument throughout their campaign (Jones 1999). Jones describes the moment nurses achieved prescribing status as "a legitimating of the status quo", Jones (2004 p272). His comment draws on the view that nurses were already prescribing in the workplace by arrangements for prescribing by proxy and patient group direction.

4.1.2. prescribing by proxy: workplace assimilation and the division of labour.

As described in chapter 2, the literature review, nurses frequently prescribe by proxy. The doctor who is asked, to prescribe on behalf of a nurse or who receives prescribing advice from a nurse uses medical knowledge to judge the accuracy of the prescribing decision and request made by the nurse. Prescribing decisions are complex requiring many different genres of knowledge. A nurse who prescribes by proxy is unlikely to have a true concept of the prescribing knowledge needed to support safe and accountable prescribing. Children's nurse CN1 gives a useful illustration,

"I was shocked that I had gone through 20 years of nursing and didn't understand the pharmacology of drugs. You could argue, well isn't that the doctor's job but something as simple as Paracetamol, I had never understood how it worked" CN2 Page 4.

Prescribing by proxy has a formal role in the claim for jurisdiction when viewed in the context of workplace assimilation. The outcome of

jurisdictional disputes is determined by the way in which the claim is controlled. Professions do not control the work by technique by developing a body of abstract knowledge, Allen and Hughes (2002). Abbott suggests that the most effective way for this to occur is to develop a practice skill from abstract knowledge, Abbott (1988). Professional control lies within these abstractions because the practical techniques generated can be delegated to others. Abbott calls this workplace assimilation. Members of one professional group will provide some members of another profession with basic knowledge to undertake a task previously within their jurisdiction and division of labour. Abbott describes the transfer as providing a 'crafted, on the job; version of the task, Abbott (1988 p65). In terms of nurse prescribing, learning on the job gives a nurse the opportunity to develop knowledge required to make prescribing decisions but without theoretical knowledge to underpin prescribing actions.

The delegating profession retains abstract knowledge of prescribing but delegates the task. This is achieved in two ways. First, medical education incorporates the theoretical knowledge which underpins prescribing. In gaining the autonomy to complete episodes of care in the legal framework of independent and supplementary prescribing, nurses develop theoretical prescribing knowledge through education. Prescribing knowledge has long been embedded in medical education and identifying the necessary elements to prescribe without full medical education is problematic (Latter et al., 2004; Leathard 2001). Defining the nature and content of theoretical knowledge necessary for non medical prescribers has been attempted (NMC 2006; RPSGB 2006; HPC 2004). However, responses from doctors participating in nurse prescribing research (Latter et al., 2004) suggest this is incomplete. The formal role of doctors as designated medical practitioners who supervise the education of non medical prescribing

students in practice is potentially a way to address the perceived gap in theoretical prescribing knowledge. Courtenay, Carey and Burke (2007b) put forward the suggestion that nurse independent and supplementary prescribers might be themselves well placed to support trainee nurse prescribers. This would in effect replace the designated medical practitioner who currently supervises the training of prescribers in practice with a nurse prescriber. Considering my findings in the context of Abbott's work and the nurse prescribing literature there is insufficient evidence to replace doctors in this role. Current medical supervision arrangements provide the nurse an opportunity to draw on medical knowledge, the theoretical knowledge of prescribing, whilst gaining experience of prescribing in social systems of healthcare. In this way nursing will continue to find opportunities to build prescribing knowledge.

Second, nurses gain prescribing authority by a process of selective delegation. Abbott builds his concept of workplace assimilation on the premise that the professions are not homogenous groups. Workplace assimilation is said to recognise the real output of the individual as opposed to the academic and professional credentials the individual holds. Doctors enable and support an able nurse to learn how to make prescribing decisions, workplace assimilation, to the point of signing the prescription. The Medicines Act 1968 states that only appropriate practitioners, doctors, dentists, vets and qualified nurse, pharmacists and allied health professionals can sign a prescription. The control of the delegating profession serves to reinforce their position in the hierarchy. Nurse prescribing is an example of workplace assimilation in prescribing by proxy and independent and supplementary prescribing.

In an analysis, Abbott suggests the problem of work place assimilation is that those individuals in receipt of knowledge lack the level of theoretical knowledge necessary to support the task. This illustrates the risk of prescribing by proxy and of non medical prescribing. Whilst the professions have sought to identify the knowledge and skills required to prescribe doctors refer to this lack of theoretical knowledge when they warn nurses that there is more to know about prescribing, Latter et al.(2004). In response to his own analysis Abbott suggests the problem of theoretical knowledge is not important because theoretical knowledge is often irrelevant in professional practice. He draws the conclusion from his observation of theoretical education in dominant professions. This argument might apply to other professions but responses from my participants suggest theoretical knowledge is important in making prescribing decisions. Their descriptions speak about theoretical knowledge and explain how this knowledge, gained through prescribing education has a positive impact on their prescribing.

"it has helped me think of and about side effects a lot more than I would have done before. If there is something wrong with the baby you have got the theoretical knowledge that you got from the course. I had a baby the other day that was on Dopamine and was really tachycardic and, I understood why that baby was tachycardic as a result of the drug and I could remember how that drug worked and what was happening and so that was really, really useful and I would not have known that before" CN2 Page 7.

" it is almost like the secrets the doctors never told us and you think why didn't I know that, it is so obvious when you learn these things and it really affects the way you practice" WIC1 Page 1.

4.1.3. standard and actual division of labour.

Workplace assimilation according to Abbott can result in a difference between the standard and an actual division of labour. In a standard division of labour, the work activities undertaken by a professional group accurately reflect the professional jurisdiction of roles expected by public and professions. In terms of prescribing in a standard division of labour, a nurse who is not qualified to prescribe would not diagnose or prescribe for patients by proxy. A standard division of labour respects the boundaries of jurisdiction of the professions. Abbott describes how in the workplace jurisdiction is a claim over certain types of work. He suggests here that jurisdiction of tasks is not subject to debate but is instead defined by what he describes as "a normally well understood and overwhelming flow of work", Abbott (1988 p64). The actual division of labour will reflect who can control and supervise the work and according to Abbott (1988) who is qualified to do what.

These intra-organisational or actual divisions of labour are therefore said to replace the standard division of labour. Actual divisions of labour reflect the reality of 'who does what' in the clinical area. In the workplace nurses are often the first point of contact for a patient who may require a prescription. An intra-organisational division of labour allows the nurse to assess, diagnose and ask the doctor to prescribe on behalf of the nurse (prescribe by proxy) or, to supply the medicine by patient group direction. Whilst the actual division of labour has allowed some nurses to prescribe by proxy changes to the legal jurisdiction of prescribing have given nurses a wider remit of prescribing than that enabled through an actual division of labour in the workplace. A new division of standard labour has to be agreed in order for the nurse to integrate this wider remit of prescribing in nursing practice.

Participants working in primary and secondary care described their approach to introducing their jurisdiction of prescribing to doctors in the team. In these excerpts participants explained that for them, the addition of prescribing to nursing roles should not be received by the medical profession as a threat to medical authority. The actions they describe show respect and reassurance.

"you don't want to be seen to be treading on his toes so it will probably be a phone call this is what is happening, this is what I want to do" PN4 Page 10.

" It wasn't their approval, it was that they have ultimate responsibility for that patient and I am doing something that may possibly change things. I ought to have the courtesy to say this is what I am thinking of doing". CM3 Page 3.

" you need their agreement really because it is politeness as it is their patient". NSP Page 6.

As they start to prescribe for patients in practice my participants acknowledge that in prescribing they take on work previously under the control of medicine. In itself this is not new as nurses have accepted many roles previously undertaken by doctors. It is that most nurse prescribers seek permission to undertake the activity which sets this activity apart from others accepted into nursing. Those participants who seek permission show respect for professional roles in the division of labour and concern for patient safety. With more than one professional group able to prescribe in the practice area the potential for poor communication is raised, as is the risk to patient safety. Permission seeking serves to acknowledge professional roles and inform the doctor of the nurse's intention to prescribe. Identifying that nurse prescribers seek permission to prescribe is

important because these prescribers have legal, professional and employer authority to prescribe. They do not require agreement from a doctor to prescribe for patients. These findings support those of Fisher who in a small study of district nurse and health visitor prescribers also found that most nurse prescribers seek permission from doctors before prescribing, Fisher (2005). In his conclusion Fisher (2005) expresses concern that permission seeking behaviour perpetuates the hierarchical relationship between doctor and nurse. Findings from these case studies suggest that permission seeking behaviour is an activity intended to maintain the hierarchy of medicine.

4.1.4. Prescribing agreements: depending on doctors to build confidence.

Accountability and responsibility are important to safe prescribing. The way in which the nurse exercises his or her accountability when prescribing is judged against legal and professional standards. The main difference between what nurses have been doing, (prescribing by proxy and advising doctors) and, nurse prescribing is accountability. As an independent or supplementary prescriber the nurse is both responsible and accountable for the prescribing decision. The nurse prescribing literature has explored how nurses feel about accepting the autonomy to make prescribing decisions and the accountability associated with using this autonomy. Rodden (2001) and Latter et al. (2004) used quantitative research methods to investigate accountability and autonomy and to determine if the autonomy to prescribe leads to reduced dependence on doctors. Participants in my case studies were not asked to rate changes to dependence on doctors but more than half of the sample described behaviour which involved asking a doctor to check prescribing decisions. I have previously described how most of my participants sought permission from doctors before prescribing for patients.

In addition, participants spoke about consulting doctors to discuss prescribing decisions before prescribing. I call this doctor checking. This doctor checking behaviour is a form of dependent behaviour where the nurse makes a diagnosis and treatment choice and will check the accuracy of decision making by asking a doctor to confirm the diagnosis and agree an appropriate treatment has been chosen. Participants describe the behaviour in the following way;

"whilst I was in the patient's home often what I was doing to begin with was going back, speaking to the GP this is what I have found this is what I would prescribe is that ok? CM2 Page 1.

"it will make me more confident in the future that yes the doctor has said yes that is the right thing". PN6 Page 4.

During the interviews, participants spoke frequently about this activity but the literature suggests having the autonomy to prescribe actually reduces doctor dependent behaviour. Rodden (2001) found that 66.5% of her community practitioner prescribers became less dependent on general practitioners, while 3% were more dependent. Latter et al. (2004) asked the same question to extended nurse prescribers and found 47.5% strongly agreed and 42% agreed they were less dependent on doctors. I accept the comparison is somewhat crude because dependency in the literature is determined by nurse prescribers and in my case studies by researcher interpretation. Acknowledging this criticism, I consider it likely that participants in these studies would agree, asking a doctor to check a prescribing decision is doctor dependent behaviour.

The difference identified in my findings can be explained in terms of an outcome of amendments to prescribing legislation in May 2006. At this

time extended nurse prescribing was replaced with full BNF independent prescribing (with minor restrictions on the prescribing of controlled drugs). It is likely that the accountability and responsibility of diagnosis under independent prescribing is one explanation for the doctor checking behaviour described by participants. My participant groups have identified a preference for using independent prescribing. This choice carries full autonomy and accountability for all aspects of the prescribing decision.

Further understanding can be taken from prescribing by proxy and workplace assimilation (Abbott 1988). Excerpts were, presented above from community matron CM2 and practice nurse PN6. Both participants were new prescribers, qualified between 7 and 13 months. Their behaviour follows the same process as that seen when nurses prescribe by proxy.

The nurse prescribing literature has established that prescribing by proxy is a common activity for nurses who later take up prescribing education (Bradley et al., 2005). Doctor checking behaviour described by my participants follows the process of prescribing by proxy to the point of signing the prescription. At this point nurse prescribing and prescribing by proxy differ because a prescribing nurse is accountable for the diagnosis and treatment plan regardless of the doctors agreement. The process of workplace assimilation is followed and the nurse uses the prescribing knowledge and skills he or she is comfortable with. To take on the responsibility of prescribing the nurse in addition, requires theoretical knowledge gained through prescribing education. Lacking confidence in the application of this knowledge to prescribing in practice the nurse will check with the doctor before prescribing. Doctor checking activities were most frequently described by participants in the group qualified to prescribe for 7-13 months. This group of prescribers were in the early stages of

developing their prescribing knowledge and skills. Doctor checking provided a way for these prescribers to check the accuracy of their decisions and reinforce their learning. Doctor checking is not therefore a behaviour intended to shift accountability but is a form of support aimed at building prescriber confidence. Latter et al. (2004) reported that some nurse prescribers lack confidence in their own ability to prescribe. Doctor checking serves to help build prescribing confidence. This leads me to conclude that doctor checking behaviour demonstrates a cautious approach to prescribing and that as prescribing experience builds doctor checking behaviour becomes unnecessary.

An interesting addition to the explanation offered so far draws on the work of Allen (1997). She suggests informal boundary work between doctors and nurses is a taken for granted part of normal nursing practice. She proposes that these boundaries are developed and maintained through 'meaningful actions' and it is possible that doctor checking and permission seeking activities are examples of informal boundary work. These activities are intended in this context to reassure the doctor that the nurse is competent and that medical authority is not challenged by this boundary change.

4.1.5. Prescribing Agreements: defining a new division of labour.

Nurses are one of several non medical professions with authority to prescribe but it is prescribing with doctors which my participants focus on. They describe how new boundaries in a division of labour are agreed. Here the role of the employer is highlighted and differences between agreements in primary and secondary care settings are shown.

My participants describe how new boundaries are agreed in their areas of practice. Cross case analysis of the data revealed a variation in approach

between primary and secondary care. My participants described several ways in which changes to prescribing jurisdiction are arranged in a new division of labour. Several participants from primary care found doctors were happy for them to define their own boundaries of prescribing practice,

" they did basically leave it up to me" PN7 Page 1.

" he didn't restrict me he was quite happy as long as I was confident with what I was doing". PN4 Page 3.

A number of primary care participants were working in new roles. The most common new role of the participant group was that of community matron. In a study of community matrons and general practitioners, Chapman, Smith, Williams et al. (2009) found in practice the role lacked definition. In the absence of a defined role, a new division of labour would be difficult to agree. As a result the matrons felt there was a barrier which prevented the community matron from working effectively alone and in the team Chapman et al.(2009). As new prescribers, the community matrons in my case studies sought to define their prescribing role. They did this by approaching and talking to doctors. Community Matron 2 describes her approach;

" I was asking her what as GP's would they feel comfortable with, what could we do and yes they have given us some guidance" CM2 Page 1 .

Community Matron 3 also describes how she approached doctors in an attempt to establish their expectations. During the interview this prescriber goes onto explain how this approach facilitated agreement about prescribing roles and responsibilities between herself and the prescribing team of doctors.

4.5.1: Illustration Case: Community Matron, CM3.

Prescribing boundaries, agreements with doctors.

Community matron CM3 had been qualified to prescribe for 14-24 months and had previously worked for the GP practice as a District Nurse. This primary care team of prescribers chose to actually move responsibility for not only prescribing but also management of patients with long term conditions to the community matron. In this partnership the doctor retained overall responsibility for the patient but lines of responsibility in this division of labour have been formally defined.

"The doctor and I, we decided that the case management patients are not all his responsibility, we discuss them and he tends to keep an overall eye on them". CM3 Page 3.

The benefit of this collaboration for patient and professional are clearly seen when the community matron describes how the partnership enables a collaborative approach to resolve patient problems.

"I went on holiday and she had 6 GP's out and they all gave her something..... after a year of messing about we put her on an extremely low dose which she has a very great faith in, it's the cheapest one and she hasn't called anyone out for 5 weeks now but we came to that conclusion with all of us sitting down and saying well should we and weighing everything up" CM3 Page 8.

"one of the patients whose oxygen sats were 72%, when he was put on steroids and after about 8 months of looking after this very lovely man he said you know I would rather have 6 months of feeling how I do now than 2 years of feeling how I do when I am not on steroids, the Gp and I and the patient sat together and discussed the pros and the cons of being on them as opposed to not being on them and the three of us made that decision, he remained on them and he lived for about 7 months but he functioned in his kitchen and he loved cooking and he did that as opposed to the terrible life he had when he wasn't on them " CM3 Page 7.

In this particular case the doctor and nurse have successfully implemented jurisdictional changes and formally agreed responsibility in the division of labour. Central to this level of agreement is trust. Both parties must undertake their commitment to work within the agreed boundaries of practice. The presence of trust in doctor nurse relationships has been acknowledged in the literature (Pullon 2008; Allen 1997) and I return to explore the issue in theme 2 'prescribing relationships'. Whilst the case of CM3 is a positive example of how a new division of labour can improve the patient experience it is important to remember that prescribing is a mandatory part of the community matron role. The formal inclusion of prescribing in the role could lead to expectation and acceptance from doctors that the community matron will prescribe for patients.

4.1.5.2.Prescribing agreements: examples from secondary care.

Nurse prescribers in primary care have described ways through which informal and formal agreement of prescribing boundaries are agreed with doctors. Cross case analysis revealed a different approach to agreements described by secondary care nurse prescribers. Secondary care organisations were found to have implemented formal frameworks within which the nurse prescribers were expected to prescribe.

Illustration cases :CN1, NSP2, NSP6, CN2.

Prescribing agreements in secondary care.

There were four secondary care nurse specialist participants;

CN1: Child continence specialist nurse,

NSP2: Sexual health specialist nurse,

NSP6: Epilepsy specialist nurse,

CN2: Neonatal advanced nurse practitioner.

My secondary care participants identified a number of restrictions imposed on their prescribing by the secondary care organisations. The arrangements described by the secondary care participants are summarised in table 4.1.

Participants working in secondary care settings expressed frustration that, once qualified, they must wait for further approval before they can start to prescribe for their patients. CN1 a senior children's employed by hospital trust G explains,

" even when we have written these disease specific proformas they have to go through committees and they get sent back so they have to go back again and, you know, that in itself seems to take months" CN1 Page 1.

In secondary care settings senior managers from the healthcare trusts participating in my study negotiate and agree the boundaries of non medical prescribing with senior members of medical and pharmacy teams. Nurse prescribers do not enter into individual discussions to identify prescribing boundaries. Instead managers agree a prescribing formulary (usually restricted) which all non-medical prescribers in the team are expected to work to. These restrictions are part of the clinical governance arrangements for the organisation and the way in which employers manage the clinical risk of non medical prescribing. The presence of restrictions by healthcare employers and their effect on nurse prescribing have previously been identified in the prescribing literature. Findings by Courtenay et al. (2007a) suggest organisation factors prevent or hinder the integration of nurse prescribing.

Table 4.1: Restrictions to non-medical prescribing in secondary care sample.

Participant Hospital Trust	Restriction to nurse prescribing.
<p>Primary Care Trust E hosts nurses working in shared primary / secondary care posts.</p> <p>NSP 5</p>	<p>Primary care prescribing -No primary care restrictions.</p> <p>Secondary care prescribing - nurse prepares list of drugs he/she wishes to prescribe. Manager must agree the list before prescribing can begin.</p>
<p>Mental Health Trust F hosts nurses working in shared primary / secondary care posts</p> <p>MH1. MH2</p>	<p>Primary care prescribing - Nurses employed by this organisation with responsibilities in primary and secondary care had no restrictions to prescribing in primary care.</p> <p>Secondary care prescribing - Nurses prepare a list of drugs he/ she wishes to prescribe. Senior pharmacist to agree the list before prescribing can begin.</p> <p>In primary and secondary care prescribing in this organisation. Supplementary prescribing is the preferred type of prescribing. To independently prescribe the nurse must enter a process of upgrade within the organisation.</p>
<p>Hospital Trust G CN1. CN2. NSP2. NSP6.</p>	<p>There are 2 systems in place dependent upon location.</p> <ol style="list-style-type: none"> 1. Directorate agreed list of drugs prescribeable by non medical prescribers. The list is agreed by senior pharmacists and doctors with responsibility in the directorate. 2. Nurse is required to develop a protocol for each drug he / she wishes to prescribe. The protocol must be ratified by the local medicines committee before prescribing of that drug can begin.

In these case studies local restrictions have not however, prevented the four secondary care nurse specialist participants from prescribing. It is likely that their roles and experience help them to accept and work within these restrictions. Case data, interview transcript, reflexive field notes and attribute data show the four are experienced nurses who have been in post for more than 5 years. As specialists their roles are likely to involve a narrow range of conditions and drug therapies. Whilst the prescribing literatures offer little to support this explanation Bradley and Nolan (2007) found that prescribers working in less defined areas of nursing feel concerned about competence and can be reluctant to prescribe. It is possible therefore to assume that where areas of practice are narrow and well defined the prescriber has greater confidence and competence.

4.1.5.3. Illustration case. Mental Health Nurse : MH2.

Choosing not to prescribe.

MH2, a mental health nurse working in an acute healthcare trust is one of five nurses from the sample group who were not prescribing. The case summary shows her to be an experienced nurse. Reflective field notes describe her as conservative in her approach to practice. During the interview she speaks at length about her concern that the healthcare organisation has no prescribing lead for her to contact to ask questions about prescribing in practice. Drawing on my knowledge of this organisation I am aware that they do have a prescribing lead but the prescribing role is part of a much wider remit of responsibilities for a senior manager. As a result of this high level of representation prescribing has been taken forward at a strategic level within the organisation. MH2 describes how she feels unsupported, vulnerable and unsure of her prescribing role. When she talks about needing a prescribing lead she refers to someone who she can ring up, ask practical questions about

prescribing and check the accuracy of her prescribing decisions. In her interview she did not speak at any time about asking these questions to the prescribing lead in the organisation. It is likely that this participant considers the sort of questions she wishes to ask inappropriate to ask a senior manager. Interestingly this participant does not talk about doctor checking during her interview. She appears to expect these needs to be met by the employing organisation through a prescribing lead at practice level. For her this need is not met and she sees the organisation as placing restrictions on her prescribing. She expressed her frustration,

" it just bugged me and I thought you know I have done all of this I am a competent nurse I have never worked outside my competency but it felt like people were waiting for you to make a mistake, you know it just irritated me, there is too much to do" MH2 Page 2/3.

This participant perceives the requirements of the healthcare organisation to signify a lack of support and trust in her prescribing knowledge. Together these factors contribute to her decision not to prescribe.

Health Visitor HV1 described how she became aware of her employer restrictions from other non medical prescribers. The verbal notification related to the prescribing of antibiotics to treat breast abscess which was said by other non medical prescribers to be forbidden. She says,

" it makes you question your ability from the point of view of well if they are not comfortable then I am not comfortable in terms of accountability then because they are in a way almost implying actually I am not too sure about your practice" HV1 Page 12.

The health visitor was not able to identify a formal notification of this particular restriction but chose not to prescribe for this particular condition.

In a study of professional identity, Ewens (2003) said that when nurses adapting to new roles found themselves to be constrained by the organisation they were likely to move back to a traditional view of themselves. Both of these participants demonstrate this effect. Employer restrictions, whether they be real or perceived affect the integration of prescribing.

My case studies show examples of how, systems within organisations can hinder and prevent the integration of nurse prescribing in primary and secondary care. These findings have implications for practice in terms of how prescribers can best be supported in practice.

4.1.6: PRESCRIBING AGREEMENTS: Theme Summary

For my participants prescribing was a natural addition to their nursing roles. Most had previously prescribed by proxy or advised doctors in the prescribing of drugs for patients. The authority to prescribe was therefore the next step in their professional development. They were very clear what the addition meant to them as nurses. Prescribing enhanced their role it enabled them to make best use of their nursing skills and knowledge. In their roles nurse prescribers were there to complement the role of the doctor and not to replace doctors. The traditional hierarchies of the professions were not challenged instead they were acknowledged and maintained by nurse prescribing. The addition of prescribing to the role of the nurse does change the standard and actual division of labour. A new division of labour must be agreed for the integration of nurse prescribing in practice to take place. Recognising that by prescribing for patients they were undertaking activity previously in the domain of the doctor my participants sought ways to define their prescribing roles with doctors. In primary care settings this involved formal and informal discussions with

doctors. In secondary care settings prescribing agreements were formal and binding. For these nurse prescribers the process required to reach agreement was not only frustrating but it delayed prescribing. Whilst the prescribers found prescribing a natural addition to their role once prescribing they began to engage in doctor dependent behaviour. Nurse prescribers, were found to seek permission from doctors before prescribing for patients. In addition, they asked doctors to check their diagnosis and prescribing decisions before prescribing. These activities were most noticeable in the first year of prescribing, reducing after this time.

In this theme the acquisition of prescribing rights and agreements for a new division of labour were described from the nurse prescribers perspective. The theme draws on Abbotts work, 'The System of Professions An Essay on the Division of Expert Labor' (Abbott 1988) to explore how the jurisdictional boundaries of medicine and nursing have changed and a new division of labour agreed.

4.2: THEME 2: PRESCRIBING RELATIONSHIPS.

The second theme to emerge from the data, prescribing relationships, adds to findings from the first theme, prescribing agreements. Relationship factors serve to promote, hinder or prevent the integration of nurse prescribing and are the focal point of this theme. In his work, Abbott works from the assumption that movement to the boundaries of one profession has an affect on others. He does not consider the effect of the individual relationships between professional people in the context of the division of labour. My findings identify trust in the relationship between doctor and nurse as a key factor for the effective integration of nurse prescribing in primary and secondary care teams. This theme will explore a group of

findings which focus on professional relationships, first those between nurse prescriber and nurse and secondly between doctor and nurse.

4.2.1.Prescribing Relationships: nurse prescribers and nursing teams.

As the division of labour between the professions changes to accommodate nurse prescribing so must the organised division of intra professional labour in the nursing team. A traditional division of healthcare labour works with legal jurisdictions that do not allow the nurse prescribing rights. In this division, patients receive medicines in a timely way using other legal frameworks for the supply and administration of medicines, Patient Group Directions (DH 2000b) and prescribing by proxy which was described in theme 1, prescribing agreements.

Bringing prescribing into the jurisdiction of nursing has, according to my participants received a mixed response from their nursing colleagues irrespective of care setting,

" it has been really funny because they were all keen for us to do it but now they seem reluctant, its quite strange" CN2 Page 4.

" I thought it would be the doctors who were against me but it has actually been my peers" MH1 Page 2.

" Here, they are the worst (indicating the nursing team in the base), they are better now (the nursing team) but, they would never come to me. I used to say so you have chased that doctor around for the last three days trying to get them to prescribe, that is one of my patients why didn't you come to me. I would have gone through it with you, I would have prescribed. I think here it took 18 months for that to happen." CM3 Page 5.

These descriptions show that some nurse prescribers have found their peers resistant to accepting or welcoming their new knowledge and skills into the nursing team. This is important because it suggests that nurse prescribing, valued by those nurses who become prescribers is actually threatened by nurses. It is difficult to conclude from these excerpts if non-prescribing nurses misunderstand the principles of non-medical prescribing. Perhaps they fail to recognise potential benefits to patients and the nursing team. It may also be explained as a form of intra-professional rivalry.

The nurse prescribing literature provides some recognition of the problem. Bradley et al. (2005) briefly refer to the potential of nurse prescribing to cause disruption to nursing colleagues in the team. Unfortunately, in the research paper the authors do not provide details of the disruption they report. Nurse prescribing is an additional qualification which, as discussed in theme 1 prescribing agreements, moves the nurses' role closer to tasks associated with medicine and consequently perhaps considered to involve higher status work. Bradley et al. (2005) suggest that nurse prescribing changes the doctor nurse relationship by moving the nurse from a subservient towards a collaborative relationship. There is therefore a potential for professional rivalry within nursing. This potential is, mentioned in the nurse prescribing literature. Bradley and Nolan include an excerpt from a participant interview where a nurse prescriber describes how the presence of a nurse prescriber in the nursing team caused 'a ruffling of feathers'. Whilst the authors offer no exploration, Bradley and Nolan (2007 p125) the phrase does suggest a similar type of response to that described by my participants. Whilst it is not possible to infer directly from this literature my findings suggest that a prescribing nurse cannot assume nurse colleagues will welcome their new knowledge and skills.

My participants also gave positive examples where nursing teams have welcomed them and their new prescribing knowledge and skills. These excerpts, one from a primary care participant and one from a secondary care participant are good examples of how nurse prescribers became a source of knowledge in the team (Bradley et al., 2005).

" I have got a lot more knocks on my door people coming in and asking my opinion" WIC2 Page 4.

" the team now come to me for advice regarding drugs, if the drug rings up then it is me, if some research comes through for the bladder I have to go through all the research and evaluate it" NSP5 Page 12.

Courtenay and Carey (2008) had suggested lack of peer support would hinder or prevent nurse prescribing. However, where negativity did present for my participants it was not a strong enough factor to prevent the integration of prescribing into practice. I conclude therefore that the support of nursing colleagues is welcomed and desirable for nurse prescribers to effectively integrate but not essential to the integration of nurse prescribing.

4.2.2. Prescribing relationships: doctor-nurse.

Several of my participants felt that working with doctors in an established team was beneficial to them in their new prescribing roles. Participants express this view using 'they know me' examples.

" it does help the fact that I have been here for 13 years, they do know me" MW2 Page 3.

" I have worked here along time the doctors have a good idea what I am capable of doing". PN3 Page 5.

" the GPs are approachable and realise the knowledge and sound base that we have got as nurses and they are you know recognising us as a fellow professional and not as the old handmaiden" PN5 Page 5.

" I think that actually there has always been a trust certainly in general practice especially when you have worked there for some time" PN6 Page 3.

In these responses my participants promote the idea that in established teams, doctors know what the nurse is competent to do and there is trust in the doctor nurse relationship. These attributes are presented as beneficial to the integration of nurse prescribing in the prescribing team. It is of course important in terms of patient safety that, nurse prescribers approach prescribing as a group activity and do not rely on individual prescribing practice (Gerhardi and Nicolini 2002). This raises a question of what happens when nurses leave a prescribing team and a new nurse prescriber comes in. NSP1 and PN4 have changed their jobs since achieving the prescribing qualification. Both these prescribers chose to establish relationships within the team and show competence in caring for their patients before prescribing in a new role.

The idea that team stability is important in multidisciplinary teams is, also supported by the literature. In a study of medical dominance in multidisciplinary teams, Gair and Hartrey (2001) found high levels of trust and respect between team members in established teams. They found team members valued each other as individuals as well as professionals. Established teams retained respect for the hierarchy of professions but at the same time the role and contributions of everyone in the team were respected and highly valued (Gair and Hartrey 2001). Sundstrom, Meuse, Futrel (1990) describe this effect as a personal compatibility factor. The work of Sundstrom et al. (1990) and, Gair and Hartrey (2001) lead me to

conclude that in a prescribing team the relationship between doctor and nurse is an important factor for the effective integration of nurse prescribing.

I draw on the nurse prescribing literature to investigate what we know about the doctor-nurse relationship in the context of nurse and non medical prescribing. The literature presents the views of doctors. Latter et al. (2004) found in their study of independent extended nurse prescribing that doctors were happy to support the nurse prescribers they worked with, doctors were less willing to comment on or commit to supporting nurse prescribers in general. In a study to investigate factors that enable or inhibit the implementation of non medical prescribing Buckley et al (2006) looked at inter- and intra-professional relationships. From interviews with doctors they report that trust and confidence in the abilities of the prescribing nurse or pharmacist are important, Buckley et al.(2006). This suggests that within the doctor- nurse relationship there is trust, which, when present, supports the prescribing relationship. This 'trust' is not automatically present but it is individual and relationship dependant as shown by my participant in the excerpts above.

4.2.3. Prescribing Relationships: An exploration of trust in the effective integration of nurse prescribing.

Findings from these case studies show that trust is important to nurse prescribers' who are seeking to integrate prescribing into nursing practice. Trust is a concept found at the heart of nursing, the code; standards of conduct, performance and ethics. The NMC (2008) sets out expectations of the profession and includes a detailed description of how the nurse is expected to justify public trust. Trust is particular to each nurse and complicated by the context and systems within which the nurse must

practice. It involves risk and uncertainty. My case studies add contextual detail enabling a useful exploration of trust in doctor-nurse prescribing relationships.

My participants describe trust in both implicit and explicit terms and in the interview data gave examples of the attributes of trust described by Hupcey. "Trust is used to describe the nature of therapeutic relationships, an intrapersonal attribute, as well as quality of inter-professional relationships, it is thought of as a need, an obligation and a virtue", Hupcey (2001 p 283).

The therapeutic relationship between doctor and nurse has expectations of trust. Participants who have worked with the doctor for a period of time believe they have built and established trust. They expect the doctor to trust them, as they trust the doctor.

"they know you and they trust you as a person and because they have worked with you I don't think it is such an issue because they have already built up that trust" PN7 Page 6.

"they know the type of patients that I am visiting and they are happy with the antibiotics, heart medicines and diuretics, the things we are doing" CM2 Page 1.

Illustration case NSP 1: Nurse Specialist 1.

Mistrust and low confidence prevent prescribing integration.

The case study of NSP 1 is an example of a situation where a lack of trust between doctor and nurse made it difficult for the nurse prescriber to agree the boundaries of her prescribing and to develop prescribing knowledge and competence in practice.

This nurse prescriber has been qualified to prescribe for twenty months. This is her third specialist role since completing the prescribing qualification. During the course she was a palliative care specialist nurse, she then took the role of community matron and more recently heart failure specialist nurse. She prescribed in her first role, undertook limited prescribing in her second and has not prescribed in this latest role. She explains,

" I think it is my confidence, I am aware I have changed roles". NSP1 Page 4.

Nurse specialist NSP1 has responsibility for a geographically disparate group of patients with heart failure under the care of general practice. Her role is to provide specialist services linking primary and secondary care. This is a new role and the nurse prescriber sought to develop her relationship with general practitioners by improving communication between primary and secondary care services. She does this by *'keeping doctors in the loop'* NSP 1 Page 1.

She describes how patients present with problems in the symptom management of heart failure in primary care. Here she identifies both a need and, an opportunity to prescribe but finds her specialist role is not, accepted by general practitioners in all of the practices she links with. She describes the point where she began to understand why she felt uncomfortable attributing these feelings to a poorly defined role. She took an opportunity to work with doctors and nurses leading heart failure clinics in secondary care and began to identify the boundaries of prescribing she would feel comfortable prescribing within. Comparing the patients she sees in primary care to those seen in clinic she observes,

"the patients they see are quite fit and they are just titrating the medication but they are quite young and have no co-morbidities" NSP1 Page 1.

"the patients I see are more complex and unstable, more likely to be pushed into renal failure" NSP1 Page 3.

She has at this point identified a lack of confidence with regard to her knowledge and justified the legitimacy of her feelings in the context of safe prescribing and her clinical role. In the first theme 'prescribing agreements' participants described 'permission seeking' and 'doctor checking'. Using these activities nurse prescribers establish boundaries of prescribing in a new division of labour and develop confidence in prescribing. Trust was identified in the 'prescribing agreements' theme as important and findings from case NSP1 provide one example which explains why. I have mentioned previously that her specialist role was not, accepted by general practitioners in all of the practices she links with. She spoke of one surgery in particular;

" one practice were really quite dismissive and didn't want nurses interfering with their patients, we didn't even go down the prescribing line but the message was very clear that they would manage their own patients" NSP 1 Page3 .

The statement suggests the presence of mistrust. While Gilbert (1998) views mistrust as an antithesis of trust Luhmann (1979) usefully suggests it is a functional equivalent to trust. The boundaries for nurse prescribing are not open to agreement within a new division of labour. Faced with this unsupportive relationship the nurse specialist chooses not to prescribe. It is interesting to consider here that this situation was probably not a result of the nurse having prescribing authority but more about the practitioner role

itself. Sanders and Harrison (2008) studied the legitimating of occupational boundaries by professions working with heart failure patients. They too found that professionals already caring for patients with heart failure treated this new occupation with suspicion.

There are similarities between this case and that of the mental health nurse MH1 described in some detail as an illustration case in theme 3, 'prescribing in practice'. When NSP 1 accepted her position as heart failure specialist nurse she was the only non-medical prescriber in the specialist area. In my field notes I describe NSP1 and MH1 as confident professionals who show determination to prescribe for patients but NSP1 does not have the same level of medical support in practice as MH1. Trust has not been reciprocal in this case study, without the support and trust of medical colleagues, confidence in her own knowledge and ability is low and prescribing is prevented.

The idea of reciprocity in a relationship of trust merges the concept of trust with that of confidence. I have previously used Luhmann's description of trust, which situates trust in terms of the confidence we have that our expectations are likely to be met. Confidence is therefore important to trust and in order to explore further, the difference between trust and confidence needs exploration. Misztal (1996) explains the difference. Trust involves a choice between alternatives, deciding whether to take the risk or not take the risk. In trust there is always an element of risk, Misztal (1996) because it is not possible to always monitor each others behaviour. Therefore a decision to trust is based upon a belief about the likelihood of others behaving or not behaving in a certain way. The decision is not determined by cognitive understanding or a calculation of certainty and is therefore considered a risk. Taking the decision to trust someone or

something requires confidence. Described as a habitual expectation by Misztal (1996) confidence requires us to consider how likely it is that trust will be reciprocated by those we choose to trust. Confidence in trust is therefore the degree of certainty which supports our expectation. Deciding if an individual can be trusted to reciprocate friendly actions, involves the individual in an awkward assessment of other peoples' probable action. The context and importance of the situation in which one decides to trust will influence the outcome of the decision.

The discussion of trust has so far, focussed on the individual. In this context trust becomes the property of the individual and, according to Misztal (1996) a function of individual personality variables. Luhmann describes three elements of personal trust. These are that trust requires mutual commitment, participants must know and recognise the situation of trust and trust cannot be demanded only offered or declined, Luhmann (1979 p42,43). He goes onto suggest that mutual commitment is a precondition for trust and that to trust is to risk. Jalava (2001) outlines Luhmanns systems approach to trust and explains his view that trust is not based on the actions of individuals but on the collective communicative actions of actors. According to Luhmann's argument, trust is the means by which modern societies manage complexity and the way in which they manage risk. It is the tendency for complexity in modern societies which is said to amplify levels of uncertainty and risk. Societies need to manage this complexity and trust is a way in which it is managed. Trust is therefore a way to reduce complexity and manage risk (Gilbert 2004).

In the context of nurse prescribing my participants identify prescribing as a situation of risk. The three themes drawn from the case data describe and explore findings to support this assumption. The nurse can prescribe

for patients who have presented to, or have been, referred for treatment. The authority to prescribe is legitimate in legal and professional terms. However, the patient is also under the care of a doctor or consultant who accepts overall responsibility for patient care, DH (2006). Risk to the nurse in a prescribing decision is personal. Should the nurse make an error in prescribing, he or she is accountable for that action to the profession and in law (DH 2006; NMC 2006). Within the spheres of accountability, Caulfield (2005) the nurse holds the trust of patient, colleague, public and employer. Nurse prescribers who choose to prescribe accept this risk showing trust in personal knowledge and skills. The risk involves the doctor in two ways. First he/she must use professional knowledge and judgement to agree that the nurse prescriber has the skills knowledge and attributes to prescribe competently and therefore to agree a new division of labour. Secondly, the doctor has overall responsibility, DH (2006) and, must make a decision based on trust to decide if it is appropriate for the nurse to use this knowledge to prescribe for his/her patient. One participant describes how she encouraged the doctor to think about and understand the responsibility of trust,

"before we did the prescribing we would write something up and they would sign it. When I ask them to prescribe now you have to sort of say to them you are signing this so you need to check it , it is your name on there as well, they just sort of say, oh its alright we trust you". CN2 page 5.

Conversely the nurse must decide if the doctor has appropriate knowledge of his / her abilities to inform a decision of competence. The nurse must in addition consider in the event of an error how likely it is that the doctor will defend the error. Participant DN1 offers this useful example,

"I don't prescribe for that practice. I feel less confident with them than other practices. It is about confidence in the GPs to be honest the practice has been operating with locums for quite along time" DN1 Page 8.

For my participants working with doctors, and developing the professional relationship was found to be particularly important to these decisions of confidence.

Situations of trust in prescribing are likely to have been played out through the authority to supply medicines by patient group direction, by prescribing by proxy and in other situations where events in clinical practice have taken an unexpected turn. Luhmann talks about mutual commitment between individuals in situations of trust in similar ways to those described by participants. Luhmann explains; building trust takes time and mutual commitment. Trust builds as one person responds to the actions of the other person. Good actions taken by one person are acknowledged by the other. The description leads one to imagine that there might be a continual building of trust but Jalava (2001) suggests it is often fragmentary.

Luhmann adds to this concept of building trust. He suggests trust built at a micro level between two people contributes to building more abstract trust on a macro level. This idea is interesting but trusting one nurse at a micro level has not been shown through my study or the prescribing literature to improve trust between the doctor and nurses, as a group of professionals.

One of my participants describes a situation where the trustworthiness of the doctor is tested and confidence in the trust bestowed is confirmed.

"When I gave out a drug on PGD once.....I actually gave out a drug to someone who had an allergy to it.....I realised the mistake as soon as I had made it and I was very well supported because it was a mistake and we are all human at the end of the day but I think it is about

acknowledging when you have made a mistake and I think the doctors here were very supportive, NSP2 Page 7.

When asked by the researcher if this had given the nurse confidence to prescribe the participant replied,

" absolutely and knowing that if you did make a mistake as long as you do not try to cover it up you will be supported" NSP2 Page 7.

When the nurse has decided to trust and is willing to prescribe participants show evidence of testing out, not only personal trust in their professional competence, but the doctors confidence in their knowledge through reciprocal practice,

" when I am in the house and they are in the middle of surgery and I am with someone who is quite sick and I will perhaps ring them and they say if you are happy with that I am happy to prescribe that for you" CM4 Page 3.

" I always say that to GPs when I am talking to them, I can do that for you if that is what you want me to do because I feel that is what they needed if that's alright with you I can start that for you. I am doing this for you, I am helping you out basically. WIC2 Page 11.

These reciprocal actions take a new perspective as these community matrons describe how their prescribing actions avert potential hospital stays.

"little old ladies with their urinary tract infections because it does knock them off their feet doesn't it so get in quick and stop them being admitted with confusion and dehydration and that has worked an absolute treat for quite a few of my ladies" CM4 Page 4.

" we started one patient on insulin in the community which is fantastic, saved so much hassle for a demented man not to have to go into hospital"
CM3 Page 5.

Nurse prescribing is reported in the literature to enable a faster response to meet patient need, avoid potential crises, address fragmentation in care services and prevent hospital admissions, (Stenner and Courtenay 2008; Bradley and Nolan 2007). My findings are a positive addition to the known benefits of nurse prescribing. These benefits are advantageous for patient and professional. Reducing or preventing hospital admissions is reported to be part of the community matron role. The effectiveness of case management in reducing hospital admissions has not, according to Hutt, Roesen, MacCauley (2004) been proven but there is evidence to suggest nurse prescribing has a potential to reduce hospital visits and prevent hospital admission. This potential offered by this opportunity is an attractive one to employers (Williams and Sibbald 1999) but is difficult to prove.

It is useful here to look at reciprocal acts in the context of a new division of labour. Allen (1997) looked at how nurses accomplish occupational jurisdiction in everyday nursing work and she argued that occupational roles must be actively negotiated within the system of work. In her paper Allen (1997) concludes that shifts in the division of labour were virtually non-negotiated. She goes on to suggest that the day to day constitution of the nurse doctor boundary is the product of meaningful actions not interactions of the field actors. Allen's idea of meaningful actions is an interesting one in terms of my prescribing case studies. I propose the ways in which doctors allow nurses to decide their own boundaries, nurses sought permission to prescribe, nurses checked doctor perceptions of acceptable boundaries and checked their diagnostic decision making are all

examples of meaningful actions. The actions play out trust and respect in the doctor nurse relationship. Doctors demonstrate their trust in the competence and ability of the nurse by allowing them to define their own prescribing boundaries. The action suggests the doctor trusts the nurse to work within competence and otherwise refer. This trust acts as a form of support and is in effect agreement to determine how the autonomy of prescribing will be used.

In his theoretical clarification of the concept of trust Luhmann argued that trust is important to explain two independent structural changes of the modern world, unmanageable complexity and increasing diversity. Both can be recognised in modern healthcare and according to Luhmann, trust, serves to increase the potential of a system for complexity by increasing the 'tolerance of uncertainty' Luhmann (1979 p50). He bases his argument on the premise that trust can no longer be based on personal trust but that it is built in a purposeful tactical manner, no longer spontaneously. Misztal (1996) agrees suggesting that expectations in professional relationships are built by a process of gradual learning during which levels of shared understanding and mutual obligation are established. Doctor-nurse relationships have to be built, developed and I suggest nurtured. Prescribers in new roles, new positions, new clinical areas or working alongside new doctors choose not to prescribe until the working relationship between them is established. Developing the relationship encourages an exchange of information which is necessary when trust is a part of problem solving, if those involved are not willing to co-operate mistrust develops.

Gilbert (2005) suggests that the promotion of trust is bound with professional roles. Professionals control information and manage risk within

systems. In these relationships of trust in nurse prescribing the hierarchy of the professions is maintained without challenge (theme 1: prescribing agreements). Trust in nurse prescribing is required to manage complex, uncertain and unfamiliar situations of significant risk to patients, professions and public.

So far this theme has focussed on the doctor nurse relationship and has explored trust in the context of this relationship. In this final part of the theme trust in the nurse patient relationship is explored through illustration case CM4.

Illustration case CM4. Community Matron.

Prescribing relationships: Trust in the nurse patient relationship.

Community Matron CM4 speaks a lot about patients in her interview. It can be seen from the excerpts below that she has a fond respect for her patients. Case data helps to explore this assumption further. The reflexive field notes describe the empathy she shows towards patients in her care. Case data lists the standards and guidelines used by the community matron in her prescribing practice. At interview she was asked to describe how she used standards and guidelines in her prescribing practice. This matron was very clear; she explains that she does not always prescribe to the standards because she says her patients do not 'slot into' them. Her description is thoughtful as she acknowledges the accountability and responsibility of prescribing in this way showing an understanding of patient accountability with an empathy which goes beyond that expressed by other participants.

" I don't know if honoured is the right word it seems precocious but yes honoured to be let into their home, you know it is quite a big thing to go

into somebody's house and sort of stipulate what you think is wrong with them but they take it on board" CM4 Page 5.

She continues....

" a working class family they don't always question what I am saying to them and I feel a bit sorry for them because I could be telling them anything really you know, I am not, but you know" CM4 Page 5.

She is talking here about the trust her patients have in her in so far as they accept her as a prescriber and trust her to make the right decision. Patient acceptability and benefit from prescribing has been explored in the prescribing literature (Berry, Bradlow, Courtenay 2008; Latter et al 2004; Brooks et al 2001; Luker et al 1997b) and it could be argued that trust in the context of nurse and patient is like that in a doctor- nurse relationship, somewhat assumed. Trust in patient- nurse relationships is explored in the nursing literature but has not been the focus of study in the nurse prescribing literature.

4.2.4: PRESCRIBING RELATIONSHIPS: Theme Summary.

The jurisdiction of prescribing has given nurse prescribers legal and professional authority to prescribe. In order to integrate prescribing knowledge and skills into nursing practice a new division of labour must be agreed in the prescribing team. Nurses working in established teams particularly in primary care settings have been delegated prescribing roles by doctors. These roles develop from knowing each other based on knowledge, clinical ability and competence. As Rushmer and Pallis (2002) point out, jobs are filled by people with all their predispositions and diversity. My participants spoke about doctors slowly letting go of some medical activities and they explained that this delegation was based on knowledge of competence and trust to work within agreed boundaries. Trust in everyday life situations and within professional practice is both

accepted and expected. Trust is taken for granted but where trust is not established in a doctor nurse or nurse employer relationship mistrust develops. In these situations the nurse will choose not to prescribe.

4.3: THEME 3: PRESCRIBING IN PRACTICE.

4.3.1. Prescribing in Practice: Independent & Supplementary Prescribing.

Consistent with findings from the prescribing literature 21 of the 26 participants reported themselves to be prescribing. Independent prescribing was the most common type of prescribing, used by 20 of the 21 participants. None of my participants reported using both independent and supplementary prescribing. It is important here to point out several specialist nurses for the management of pain working in secondary care settings were invited to take part in this study but declined. The restrictions to the prescribing of controlled drugs means that these nurses would need to adopt independent and supplementary prescribing for their patients. Practice nurse PN3 and continence nurse specialist NSP 5 had used supplementary prescribing since qualifying but at the time of interview were only using the framework of independent prescribing. This decisive split towards independent prescribing is not in keeping with the nurse prescribing literature, which suggests supplementary prescribing has greater use than my findings suggest (Bradley and Nolan 2007). They also report that most nurses use both independent and supplementary types of prescribing (Bradley and Nolan 2007).

4.3.1.1. Illustration case MH1: Mental Health Nurse.

Supplementary prescribing.

This nurse working with patients diagnosed with mental illness was the only supplementary prescriber from the sample. It is useful to look at this

single case in more detail to establish why supplementary prescribing was used. The participant is a community mental health nurse who at the point of qualification, was the first nurse prescriber in mental health trust F. My case summary describes him as “an innovative and enthusiastic nurse with vision and determination to use the prescribing qualification”. As is the situation here, Snowden (2006) points out not only that mental health nurses have been slow to train as prescribers but, that those who do find themselves leading the way.

As the first nurse prescriber in the organisation the only examples of prescribing in practice were medical systems of prescribing. MH1 describes how he began to think about how, as a nurse he could use prescribing within his role to improve service delivery and benefit patients with a mental illness. He planned ahead and started to think about how he would use prescribing in his practice whilst still on the prescribing course. Two senior psychiatrists facilitated his mandatory period of medically supervised practice (NMC 2006). Having built on an existing clinical relationship with them through education he decided to explore their expectations. He described their reaction when he asked them how they thought he could use his new prescribing skills.

"I went to the two consultants who had supported me throughout and said where do you envisage me fitting in the service, after they had got up off the floor laughing they sort of went well you might consider doing some of the work that we are doing at a level that is appropriate for you" MH1 page 1.

The fact that MH1 describes their reaction suggests that the question might have been unexpected, perhaps a somewhat forward suggestion to change the division of labour. However, by asking the question the nurse

demonstrates his intention to prescribe for patients with mental illness and seeks their support in achieving this aim. Unusual to this particular case is that the nurse does not intend to integrate prescribing into a current nursing role but to develop a new prescribing role. The request is accepted and the psychiatrists offer the opportunity to develop a new service for the client group. The outcome is a nurse prescriber led non-medical prescribing clinic. In this system, primary care doctors refer clients to the psychiatric consultant. The psychiatrist reviews the client record and refers appropriate clients to the non-medical prescribing clinic. In this setting the division of labour is changed considerably because the nurse prescriber sees clients who would have otherwise been managed by a psychiatrist. By choosing to integrate nurse prescribing in this way the participant has allowed the psychiatrists to determine the nurse prescribing role and the type of prescribing. The health care trust has a prescribing policy in place which allows independent prescribing and supplementary prescribing. The participant explains that he would feel confident using independent prescribing and goes on in the interview to justify at some length through an explanation of the differing accountability between independent and supplementary prescribing,

"independent prescribing, I would feel confident going into that arena"
MH1 Page 6.

" legal awareness would, I think, be different, not necessarily the next level up, it would just be a different sphere of prescribing for me". MH1 Page 6.

The decision to use supplementary prescribing is determined by the consultant psychiatrists;

" I have spoken to the consultant and he said, well you know in my opinion it will be a challenge for you independent prescribing it is

something we will have to sit down and discuss, and I have sort of said if I feel that I need to do independent prescribing” MH1 Page 4.

There appears to be some conflict between the nurse prescriber and the expectations of the psychiatrists who provide the opportunity for the nurse to prescribe. It is possible that the psychiatrists find supplementary prescribing professionally comfortable, Lloyd and Hughes (2007) and are therefore reluctant to support the implementation of independent prescribing. The participant accepts the rationale for caution and offers an acceptable reason for staying with supplementary prescribing

“at the moment I don’t need to because I have got access to two consultant psychiatrists and there is no need for me now to be doing independent prescribing, I am very comfortable with what I am doing ”. MH1 Page 4.

MH1 has drawn on a doctor-nurse relationship built through clinical practice and prescribing education in order to create and agree a new division of labour. The psychiatrists support the creation on the non- medical prescribing clinic and both parties show trust and professional respect, which enables this to happen. The final agreement is acceptable to both parties for whilst the nurse prescriber gains the autonomy to prescribe for these patients the psychiatrists retain control of the way services are offered. It appears unlikely that the psychiatrists would agree to support independent nurse prescribing for MH1 at this time. Supplementary prescribing is a tool of compromise which actually enables the integration of nurse prescribing in this case.

4.3.2. Prescribing Practice: supplementary prescribing falls from favour.

The participants who were prescribing under independent prescribing arrangements explained why they had not chosen to prescribe under arrangements for supplementary prescribing.

"time issues" PN3 Page 1.

"it seems more complicated" NSP3 Page 8.

"seems such a rigmarole" CM3 Page 7.

The reasons described by my participants are consistent with findings from a study of pharmacist supplementary prescribing by George, McCraig, Bond et al. (2007). The legal framework for pharmacist prescribing at the time of his research was restricted to supplementary prescribing and his respondents listed the practical difficulties caused by these arrangements. To prescribe under supplementary prescribing arrangements the independent prescriber (a doctor or dentist) must prepare with the supplementary prescriber (a non medical prescriber) a patient specific clinical management plan. The supplementary prescriber cannot prescribe for the patient until a plan has been written and agreed by doctor, non medical prescriber and patient, DH (2005). The practical difficulties in preparing the clinical management plan that are reported in findings from George et al. (2007) are similar to comments from my participants. They highlight the inconvenience preparing the clinical management plan causes them. These practical difficulties hinder and in clinical areas where doctors are not working will prevent supplementary prescribing. In the case of MH1 the nurse prescriber was given little option but to use supplementary prescribing. Most of the participants in my case studies have chosen not to

prescribe under supplementary prescribing for reasons stated above. According to my participants supplementary prescribing is the least preferred type of prescribing and independent prescribing is the preferred type. These findings contrast with the picture portrayed in the nurse prescribing literature. There is however, a likely explanation for the change found.

In her study Bradley et al. (2005) reported her sample were involved in more supplementary than independent prescribing and found a third of her participants used independent and supplementary prescribing. The Bradley study was undertaken in 2005. At this time supplementary prescribing was the only prescribing option open to many nurse prescribers. At this time the Extended Nurse Prescribers Formulary restricted the medicines an independent nurse prescriber could prescribe. The formulary allowed the nurse to prescribe independently in treating patients with minor illness, minor ailments and in palliative care and health promoting situations. The extended nurse prescribers formulary did not include the medicines a nurse would need to prescribe for patients with long term conditions or chronic illness, for example asthma, diabetes or hypertension . At this time, nurses could only prescribe these groups of drugs under arrangements for supplementary prescribing. Nurses were more likely therefore to be using both independent and supplementary prescribing. For example, a practice nurse would use independent prescribing for minor illness clinics and supplementary prescribing to prescribe for patients with long term or chronic conditions. Participants in my case studies of nurse prescribing show that the practical difficulties of supplementary prescribing hinder the use of supplementary prescribing in practice. This in conjunction with the discontinuation of the Extended Nurse Prescribers Formulary, DH (2006) and authority to prescribe independently all licensed medicines (with some

restrictions for the prescribing of controlled drugs) has led to a preference for independent prescribing. This finding is important to practice because patients who could have their prescribing needs met through supplementary prescribing are being denied this service because nurse prescribers find the arrangement complex and cumbersome.

4.3.3. Prescribing in Practice: nurse prescribers not prescribing.

At interview, 5 of the 26 participants said that they were not prescribing (PN2,GN1,PN6, MH2, NSP1). Of these non prescribers NSP1 had prescribed since qualification but had recently changed jobs was not prescribing in the new role. PN2 and GN1 had not prescribed since qualifying 14-24 months ago and both MH2 and PN6 had not prescribed since qualification 7-13 months ago. The participants identified a number of reasons for not prescribing. The reasons given concur with factors found to prevent or hinder prescribing and reported in the literature review. The factors are, changing jobs, the inability to produce computer generated prescriptions and a lack of employer support (Latter et al., 2004). PN6 and PN2 reported that they were unable to prescribe on the computer system in the practice. This technical factor has been reported previously by Latter et al. (2004) and Courtenay and Carey (2008) and is known to prevent prescribing. The computer system was set up for the nurse to prescribe however it was the additional software requirements for dispensing medicines within the practice that was causing the problem for these practice nurses. The practice manager for (PN6) was working with the software company to solve the problem. PN2 had not sought a solution to the problem.

The non prescribers took the opportunity during their interviews to explain why they were not prescribing and to describe how they were using prescribing knowledge in practice. The need to explain is likely to reflect a

desire to justify to themselves and others why they completed the course but have not integrated prescribing into their nursing practice. The most interesting of these explanations is a practice nurse PN 2.

4.3.3.1. Illustration case PN2 : Practice nurse.

why I am not prescribing.

This practice nurse is employed in a rural general practice surgery. The surgery covers a wide geographical area and frequently provides care for tourists visiting the area. She is one of two prescribing nurses in the practice and works part time. She was asked at interview why she decided to access prescribing education.

"I felt that it would be valuable to actually understand some of the underlying reasons why people are prescribed the medicines that they take and their actions and interactions and so it was not from the practical prescribing point of view but more from the intellectual point of view about medicines really" PN2 Page 1.

Her rationale is different to her prescribing colleagues in the participant group who give clinical need as their reason for accessing the course. In the context of practice PN2 works in an a healthcare setting where there is clinical need and although the prescribing course did inspire an intention to use prescribing in practice, post course the intention was initiated but not completed. The interview explored why this occurred and viable justifications are offered,

"writing clinical management plans too onerous"..... "have to hand write my prescriptions, why when I am able to generate prescriptions on GP pads which would then be checked through". PN2 Page 1.

This nurse prescriber and a second practice nurse PN6 who was also not prescribing work in dispensing practices. The computer software designed for dispensing practices does not readily accept nurse prescribers. As mentioned above PN6 was, with the help of the practice manager actively seeking to resolve the problem. The nurses can however prescribe by handwriting the prescription and entering the details of the item prescribed manually into the patient record. Both nurses were unwilling to prescribe in this way. They explain this is because the computer software system which generates prescriptions has an interaction check which alerts the prescriber to potential interactions, cautions and contra indications when prescribing. Both PN1 and PN6 considered this an essential check of their prescribing. PN1 expresses this in the excerpt above. PN1 considers a second check important. She explains,

" I have not really taken the step between prescribing on my prescriptions and prescribing on their prescriptions" PN2 Page 3.

This participant has said that she did not enter prescribing education wanting to prescribe and since qualifying she has not actually prescribed. There is however, evidence to suggest that she has integrated prescribing knowledge into her professional nursing knowledge.

"I now speak to the GP's far less about the next step" PN2 Page 2.

She has developed her decision-making knowledge and skills in relation to prescribing but she continues to prescribe by proxy. It is not clear if she has been unwilling or unable to change her practice and feel confident enough to take accountability and responsibility for her prescribing decisions, she comments

"maybe if I had been put in a position where I would have to prescribe off my own back I would have got on with it and built on that knowledge base but if it is not needed, don't do it really" PN2 Page 6.

Reflexive field notes are in this case interesting because the nurse comes across as knowledgeable, competent and someone who could be prescribing independently. The transcript is difficult to interpret because in her mind she is using her prescribing knowledge, making prescribing decisions and writing prescriptions. She talks about the prescribing she does yet at the same time states she has not prescribed and actually in legal terms she has not prescribed. Her integration is incomplete while she has integrated prescribing knowledge into her professional knowledge she has not integrated the combined knowledge or used it to develop her prescribing skills. Findings from illustration case PN1 show how the knowledge and skills acquired through prescribing education affect clinical decision making even when the nurse chooses not to prescribe. This participant was unable or perhaps even unwilling to start prescribing for her patients.

4.3.4. Prescribing in Practice: approaches to the integration of prescribing.

We know from the literature review and from my case study findings that just over three quarters of nurses who undertake prescribing education will, once qualified begin to prescribe, Bradley and Nolan (2007). It was my aim, through these case studies of nurse prescribing, to investigate how nurse prescribers in primary and secondary care integrate prescribing into nursing practice. Integration in this context is about combining and acceptance. Combining professional and prescribing knowledge and skills and starting to prescribe for patients. To enable the nurse to prescribe the

nurse prescriber must first accept the role of the prescriber. In addition, the healthcare team must recognise and facilitate the new prescriber role. At interview, I asked my participants to tell me about how they started to prescribe. The descriptions were analysed at the third stage of data analysis and using cross case analysis common approaches began to emerge. There were three approaches described by my participants. They are; as opportunities present, condition specific and individual specific.

Approach 1: As opportunities present.

The prescriber takes an 'as prescribing opportunities present' approach. A full consultation with a patient is undertaken. Should a prescription be necessary and the prescriber feels competent and confident an independent prescribing prescription is written. If the prescriber is not competent or lacks confidence the patient / client is referred to another prescriber and / or supplementary prescribing is set up. Specialist nurses who prescribe in a specialist area most frequently described this approach. The condition(s) and range of drugs this nurse is likely to prescribe are limited.

" anything that comes along I first look on our list to see if it is something we can prescribe and I will look it up and if I am happy to prescribe then I will do" CN2 Page 5.

Approach 2: Condition specific.

Before starting to prescribe the prescriber identifies specific diseases or conditions, clinics or patient groups in which or, for whom they feel competent to prescribe. Following a full consultation the nurse will prescribe independently, refer or set up supplementary prescribing. These prescribers will go onto introduce prescribing into other areas of their role

as knowledge and prescribing confidence increases. General prescribers who treat a wide range of conditions for patients of all ages most frequently described this approach.

" I deal with a lot of minor illness and I decided that the easiest thing to deal with first was the ones from triage" PN3 Page 1.

Approach 3: Individual specific.

The prescriber takes a patient specific approach. Prescribers start by prescribing for patients they know well and slowly build a small group of patients for whom they regularly prescribe. As with the other approaches following a full consultation the prescriber will chose to prescribe independently, refer or set up supplementary prescribing. Knowing the patient and their past medical and medication history is important to these prescribers as their patients often have co-morbidities and multiple drug therapies. For these prescribers it is a way to manage the risk of prescribing for patients with complex conditions. As confidence, knowledge and prescribing experience grows the number of patients prescribed for increases. Those caring for patients with complex conditions most frequently described this approach.

"getting to know my patients and getting used to what drugs they are actually on...it is the worry of interacting at first " CM4 Page 1.

Approach 1, as patients present, is an approach which follows a medical system of prescribing throughout. This approach is familiar to healthcare professionals, patients and public and probably reflects the expected form of prescribing integration. Approach two, condition specific and three, individual have not been described elsewhere. The prescribing literature explores levels of nurse prescribing, types of prescribing, barriers to

prescribing, prescribing confidence and competence but does not describe how nurses approach the integration of prescribing. These findings represent new knowledge of how nurse prescribers integrate prescribing in primary and secondary care. Nurse prescribers have developed their own approach to integrate prescribing in practice. I have already highlighted a connection between the role of the nurse prescriber and the chosen approach to prescribing. The case data shows evidence to suggest that there are additional factors which might influence the choice of approach.

Data highlights four areas;

- Role
- Competence to diagnose, treat and manage disease with drug therapy. Use of guidelines and standards in prescribing decision making.
- Change to the professional assessment / consultation
- Accountability

4.3.4.1. Role.

The sampling strategy chosen for this study draws together participants from a variety of primary and secondary care setting. Five NHS Trusts who provide healthcare services to patients in primary and secondary care settings employ these nurse prescribers. The idea of this broad representation was to create a set of case studies that focus collectively on prescribing but individually on prescribing across a range of healthcare settings and for a wide range of client groups. The final sample achieves the diversity required. My participants represented both general and specialist arenas of nursing practice. All of the participants were able to describe how prescribing for patients and their prescribing knowledge has been integrated into nursing practice. Collectively, data from my case

studies leads me to conclude that prescribing is an appropriate activity for nurses in all areas of nursing work. Findings do however show connections between the nurse's role and the chosen approach to the integration of prescribing in practice.

From the diverse group of prescribers findings emerge which suggest that, for some participants the nursing role would be difficult if not impossible with no authority or autonomy to prescribe. As a group of participants, the community matrons describe their job as difficult without prescribing. This is understandable because prescribing is a mandatory requirement for nurses in community matron roles.

Community matrons respond to the complex patients for whom they are expected to prescribe by taking the cautious start of approach 3. Nurse specialists also identify prescribing as an essential part of their role. NSP2 is a nurse specialist in sexual health describes her job as impossible without being able to prescribe.

4.3.4.2: Illustration Case NSP2:

my job is impossible without prescribing.

NSP2 is an experienced nurse specialist in sexual health. Reflexive field notes and interview transcript state that at the time she completed her prescribing education she was running a nurse led clinic in a secondary care setting. Her clinics were planned to run at the same time and, in close proximity to a doctor led clinic. This provided the opportunity for the nurse to ask the doctor to see patients requiring a prescription during the clinic. This particular case is a good example of how a new organisation of healthcare service creates opportunities for nursing roles. Hospital trust G and primary care trust A agreed for the nurse specialist to run nurse led

clinics in primary care settings. Her prescribing qualification has enabled the successful development of this new service for patients. Without a nurse prescriber in these posts a doctor is required to be present in the community to prescribe for patients accessing healthcare at this point.

"I couldn't do my role without nurse prescribing" NSP2 Page 4.

As a specialist nurse with a narrow range of conditions to diagnose and a limited number of medicines available to treat the presenting conditions approach 1 is preferred by this nurse prescriber. All the nurse specialists in the sample group had started to prescribe using approach 1. Nurse prescribing facilitated the financial and clinical acceptability of this new service development. NSP2 reports that it has proved very popular for patients who prefer the anonymity of attending a community health centre as opposed to a named centre within the hospital.

4.3.4.3. competence to diagnose and manage disease with drug therapy.

When my participants spoke about prescribing in practice at interview they frequently used the words confidence, competence and comfort to describe the boundaries of their prescribing practice.

"but I certainly was not comfortable to begin prescribing COPD medications or heart failure medication" NSP1 Page1.

" there are areas I don't feel comfortable prescribing, certain children's conditions I certainly wouldn't feel comfortable in prescribing". WIC 2 page 2.

"we are working within our competence and if we are seeing anything that we are not sure how to deal with we call on them anyway [the doctors]" PN1 Page 2.

My participants find a way to manage their feelings of uncertainty by placing for themselves boundaries for prescribing. Beyond these boundaries they are clear that patients must be referred to the doctor.

"the doctors are very skilled they have got years of experience and that is the reason that you approach them when you need help and it is beyond your limitations and that is the key" PN3 Page 10.

Three words, confidence, competence and comfort, provide a sort of rationale, an explanation for the approach taken to prescribing and the boundaries that determine when the nurse will, and will not prescribe. The boundaries created by the nurse are flexible; this example from PN7 shows how nurse prescribers work to develop competence and confidence,

" with contraception I thought before I start initiating new pills I really want to do an update and I was encouraged to do that quickly. It has given me a lot more confidence to prescribe in that area". PN7 page 2.

Expressions of competence, confidence and comfort are ways of expressing the uncertainty prescribing presents. Uncertainty affects the nurses approach to prescribing and in these situations the nurse will use boundaries to limit prescribing. PN7 above had chosen not to prescribe for patients who wanted to start on the contraceptive pill. Her boundaries changed as confidence and knowledge grew. In this excerpt NSP6, a nurse specialist in epilepsy shows confidence in her prescribing ability.

" If it is a new drug I feel as confident as anyone does prescribing a new drug because even if someone else prescribed it is me that gets all the phone calls about what is right and wrong with it " NSP 6 page 6.

Feeling of confidence competence and comfort affect the chosen approach to prescribing. Nurses who adopt approach 1 show high levels of

confidence and competence. Approaches 2 and 3 reflect a lack of, or lower levels of competence, confidence or comfort in some areas of prescribing.

4.3.4.4. the professional prescribing consultation.

Nurse prescribers in primary and secondary care agree that the way they undertake their consultation or professional assessment changes as they take on the prescribing role. Nurse prescribers are able to describe these changes which begin during the process of prescribing education. These participants from primary and secondary care describe changes to the focus of their consultations,

"prescribing is the last bit, it is more about history taking" PN5 Page 6.

"I take more of a drug history than before " PN1 Page 7.

"it does make you think about ways of consultation and communication and things really you know some patients do need you to be more direct and focussed and some people want to take the decision whilst others want you to make the decision" CN1 Page 5.

Changes to the traditional nursing assessment or consultation emphasise the medicine and medical history from the patient. These elements of consultation and the ability to undertake a physical assessment when necessary are essential to any consultation, which may result in a decision to prescribe. Incorporating these prescribing skills into nursing practice enables the nurse prescriber to gather information from the patient and, or carer, which is necessary to inform the prescribing decision. WIC2 explains,

"I have only actually treated 3 chest infections since I have had my prescription pad. It is all about knowing when they are and when they are not. With physical assessment skills I am a lot happier about the diagnosis and more confident in what I am doing" WIC2 page 6.

4.3.4.5. guidelines and standards in nurse prescribing.

Participants were, asked to describe at interview how they used guidelines and standards when prescribing. The most frequently cited guidelines and standards were produced by the national institute for clinical excellence (NICE) but those produced by other similar national organisations were also frequently cited. Each participant named one or more national standards or guidelines they referred to when prescribing for patients. Practice nurses referred to a greater number of standards and guidelines than other prescribers. Participants spoke about how they used these documents to inform prescribing practice. Most participants said that they always prescribe within national and local guidelines.

" I adhere to guidelines 100% " MH1 Page 13.

" You cannot prescribe something if it is outside the guidelines you know you have to prescribe within the guidelines basically" NSP2 Page 10.

Several participants recognised where prescribing outside the guidelines might be necessary.

" you will find times when you cannot use them [guidelines and standards] because also you have to use clinical judgement" PN3 Page 4.

" I check the guidelines but not every patient is text book to the guidelines" CM4 Page 3.

Participants said that in situations where it was considered inappropriate to prescribe within the guidelines for a particular patient they would refer back to the doctor. In the following excerpt three of my practice nurse participants describe how they use guidelines and standards when prescribing.

" You do take each patient on their own merit but within that framework and if there wasn't that framework I think I might be floundering a bit more" PN2 Page 2.

" following the guidelines gives clear pathways so it makes it easier as a prescriber I think" PN5 Page 3.

" I think they are another safety valve for us, there is standardisation across the practice that this is what we do" PN6 Page 6.

These three responses suggest the nurse prescribers might use guidelines and standards to manage a gap in knowledge and enable prescribing.

Rycroft-Malone, Fontella, Blick (2008) suggest that using guidelines and standards in healthcare practice has a number of benefits. One in particular they identify is that their use serves to promote the standardisation of practice. This can be important for nurse prescribers who are potentially working in a team of prescribers where each consultant has a different preferred prescribing list to treat the same condition. Another reported benefit is that guidelines and protocols facilitate and support the extension of nursing roles through new models of service delivery, Rycroft-Malone et al.(2008). Nurse prescribing has a key role in these policy developments and the fact that nurse prescribers are using these documents to inform and support their prescribing is a positive step for practice. However, in the literature there is evidence to suggest that when training is inadequate nurses working in extended roles rely on protocols and guidelines (Main et al., 2007). SmithBattle and Diekemper (2001) describe the use of protocols and guidelines in this way as 'cookbook nursing'. Here expert decision making is reduced to following a flow chart. Such action raises the potential for acting by rote and adopting the sort of tick box mentality Illot, Rick, Patterson et al. (2006), which in the context of prescribing has the potential to put patients at risk. Nurse prescribers are accountable for their

prescribing decisions and how they choose to use guidelines, protocols and standards should be based on a clear understanding of this accountability.

Excerpts from three of my practice nurse participants are presented above. Their responses suggest that nurse prescribers working in general practice use protocols, guidelines and standards to inform much of their prescribing practice. This use can be explained in part by their clinical role. The general nature of practice nursing in conjunction with financial payment to general practice through the Quality and Outcomes Framework (QOF) itself based on guidelines and standards, offers a justifiable reason. Rycroft-Malone et al. (2008) found that doctors in primary care were more likely to be using protocols and guidelines than their secondary care counterparts because they represented performance targets linked to financial reward. Such influences are likely to be reflected in their chosen approach to prescribing.

4.3.3.5. accountability and independent prescribing.

Unlike nurse prescribers in previous nurse prescribing studies my participants have more choice about using independent or supplementary prescribing. The prescribing nurse in my case studies must make a decision about the most appropriate type of prescribing based on clinical knowledge, prescribing knowledge, patient need, requirements of employers and the prescribing environment. Some participants found the choice overwhelming,

" at the beginning I thought I wouldn't be able to prescribe anything and then I thought 'oh my god' I can prescribe everything, then 'no' I can't because I am not competent and I know I don't have to prescribe everything but I felt pressure and a whole mixture of things". MW1 Page 9.

"there is so much that I feel frightened to do anything and yet, why should I because I wouldn't do anything outside my competence anyway". MH2
Page 3.

These are interesting responses and likely to be associated with the accountability, responsibility and autonomy of prescribing, particularly with independent prescribing. Luker et al. (1998B) also found nurse prescribers to be uncomfortable with the uncertainty of prescribing. Her work explored influences on decision making by district nurse and health visitor prescribers. This group of prescribing nurses have limited prescribing authority and prescribe from the Community Practitioner Formulary which is listed in the British National Formulary (BMA and RPSGB 2009). The formulary includes a very small number of medicines which have a systemic affect on the body and the majority of conditions for which the nurse can prescribe are minor illnesses. Findings from my case studies considered in the context of Luker's findings suggests that it is the act of prescribing as opposed to the formulary from which the nurse can prescribe which is the real source of uncertainty. Findings from Avery and Pringle (2005) and Stenner, Courtenay and Carey (2009) suggest that the rapid expansion of non-medical prescribing rights increase anxiety over safety, support this view. These findings lead me to suggests that restricting formularies in practice may actually be of benefit to nurse prescribers who initially lack confidence in taking accountability for prescribing decisions. There are further practice implications as nurse prescribers need strategies to work through potential and actual issues arising from accountable prescribing. Faced with feelings of uncertainty and concerns about accountability my participants were more likely to take approach 2 or 3 when starting to prescribe.

Mental health nurse MH2 had not found herself an approach to start to prescribe. The uncertainty of prescribing appears to have overwhelmed her. In theme 1, prescribing agreements, I presented details from the case MH2 and discussed how she interpreted employer requirements for prescribing to demonstrate a lack trust and confidence in her ability. Together these elements became insurmountable to her and whilst qualified for 13 months at the time of interview she had not prescribed. MH2 is one of 5 non prescribers in the participant group (GN1,NSP1,PN5, MH2,PN2).

MW1, a midwife, takes a different approach to address the uncertainty. She accepts her prescribing qualification allows her to independently prescribe almost all drugs included in the British National Formulary. She tackles the problem of boundaries by looking into her professional role. She identifies what she thinks other healthcare professionals she works with would expect of her as a prescriber. Within this framework she identifies boundaries of prescribing within which she feels comfortable.

" I would never alter someone's medication, I have people coming and saying things like I want to go back on my antidepressants and I say yes well we will talk to the psychiatric nurse and the GP because they need to assess you as that is their area of expertise". MW1 Page 3.

The data suggests that the majority of participants are using independent prescribing which means that they are taking accountability for diagnostic and treatment decisions. Independent prescribing is the dominant type of prescribing in the participant group. Therefore, when my participants spoke about confidence and competence in prescribing they framed their descriptions in the context of accountability within independent prescribing. Moving from the role of none prescriber to prescriber the nurse prescriber

must reassess previous understanding of accountability and take on board accountability for prescribing.

" at the end of the day it is you that is signing it and that is very different to someone else signing it for you". CN2 Page 6.

" I know you are always accountable but it certainly does make you focus"
PN7 Page 8.

" when they get the prescription from me they get the do's and dont's of the drug and they have the telephone number so things are usually picked up and that whole thing is complete and I quite like that because then it is my responsibility if they develop a rash or something like that" NSP 6 Page 5.

Acknowledging this difference shows the participants understand the importance of accountability in prescribing. Accepting this accountability leads some of the participants to take a cautious approach to prescribing.

" I know I have litigation written across my forehead, you do I think, you just worry don't you when you take on an extended role you are frightened of making a mistake and I think that is why you cant afford to be blasé"
PN3 Page 8.

Approaches 2 and 3 are cautious approaches to starting to prescribe for patients. As confidence and prescribing experience build, the nurse prescriber will usually lift these early restrictions. Bradley and Nolan (2007) and Latter et al. (2004) found many nurse prescribers start as cautious prescribers and describe how confidence builds over time prescribing. Quantitative statistical analysis in the Latter et al. (2004) research identified a correlation between the age of the nurse prescriber and prescribing confidence. Older nurses were found to be more confident prescribers. Cross case analysis using case attributes failed to identify

evidence of a similar correlation in my case study sample. It did show however, that prescribing confidence grows with the length of time prescribing as this excerpt from community matron 2 after prescribing for 10 months shows.

" it is really probably in the last 3-4 months that I am now feeling more confident and I am feeling more comfortable with the drugs that we use a lot of" CM2 Page 1.

The four key areas listed below, influence the nurse prescriber in decisions about whether or not to integrate nurse prescribing and how to integrate it.

- Role
- Competence to diagnose, treat and manage disease with drug therapy. Use of guidelines and standards in prescribing decision-making.
- Change to the professional assessment / consultation
- Accountability

The three approaches to prescribing in practice described by my participants provide a useful context from which to explore how the process of nurse prescribing integration occurs.

4.3.5: Ties and tasks of jurisdiction.

As I have previously described, prescribing is an activity associated with the traditional role of medicine. According to Abbott (1988) tasks, such as prescribing, have what he describes as subjective and objective qualities. Objective qualities tie tasks together. For example the task of prescribing is tied to the task of diagnosis. Abbott describes how changes to objective qualities are in fact external factors which challenge the legitimacy of the task associated with the current holder. This concept is central to his

discussions of inter- professional conflict and claims of jurisdiction. Subjective qualities come into play when the activities of one profession impinge on those of another. He argues that subjective qualities of a task arise within the present construction of the problem by the profession currently holding jurisdiction of the task. Central to Abbott's thesis is the presence of constant inter-professional competition through which claims for jurisdiction over tasks are made. In his thesis he does not attempt to explain how new divisions of labour arising from claims of jurisdiction are established in the workplace. The concept of subjective qualities is however an interesting one. If as Abbott argues, tasks have both subjective and objective qualities, moving jurisdiction of prescribing into nursing moves the task of diagnosis into the objective tasks of nursing. Subjective qualities are, according to Abbott "imposed by the present and past culture of the task" Abbott (1988 Page 36). In this way the integration of prescribing in practice is contextualised within the power and authority structured by gendered relations of dominance of subordination Witz (2002).

One outcome of this successful claim for jurisdiction of prescribing is that nursing gains jurisdiction of both prescribing and of diagnostic tasks. These tasks of prescribing are however constructed by the current and sharing holder, the medical profession. My participants describe different approaches to starting to prescribe in practice. They highlight the importance of trust in the doctor nurse relationship. It appears then that nursing is reconstructing the problem of prescribing in a new division of labour. These new subjective qualities of the task are complementary to those of medicine, but they are different.

4.3.6: Prescribing in practice.

Positive outcomes of integration for patients.

Participants explain how nurse prescribing enables patients to receive medicines and they give examples from practice to support the view that patients find nurse prescribing acceptable.

"you are picking them up there and then you can prescribe there and then and it is not another appointment for them" HV1 Page 5.

" It was great I could prescribe, it would have been a long winded sort of situation and he may not have been able to get his antibiotics until perhaps 8 at night and so it was a huge benefit something simple that makes a big difference" CM4 Page 10.

"Comments I get (from patients) through telephone triage if they are coming in, 'oh but will you be able to do the prescription' because they feel if you cant they don't want to waste your time" " Having to waste patients time by coming back for scripts or disappearing out of the consultation breaks continuity up" PN3 Page 2.

These excerpts suggest that being able to prescribe enables the nurse to meet the prescribing needs of their patients. This appears to be particularly important to patients presenting in primary care. In order to enable a comparison between nurse perceptions and patient views it is necessary to determine how patient views are, presented in the literature. When patients talk about the acceptability of nurse prescribing, they frame their responses in two ways. First by asking how does nurse prescribing fit with public and patient perceptions and expectations of a nurse? Patients draw on the attributes of nursing for comparison. Nurses are seen as, approachable, knowledgeable and continuously involved in patient care. These attributes are, considered by patients to be commensurate with a prescribing role. Because these case studies are of nurses and not patients'

my findings do not add to the patient literature in this way. In the second frame patients consider prescribing and how they wish to receive medicines. Patients talk of wanting easy access to services, of convenience and of choice. The attributes of nursing and the role of the nurse reassure patients that nurse prescribing is an acceptable way for them to receive medicines.

One of the most important points to come out of the nurse prescribing literature is the finding that patients and public expect prescribers to give information about the medicines they prescribe (Latter et al., 2004; Berry et al., 2006). The responses given by my participants suggest the nurse is well placed to meet this need. Many of my participants explained that talking to patients about the medications prescribed for them was part of their role before they became prescribers. Knowledge gained through prescribing education, in particular pharmacology knowledge has enhanced this role. PN3, Practice nurse 3 explains,

" it is not always about prescribing but giving them adequate safe advice really and as I say I used that from the very beginning and found that was the biggest thing that I was putting to good use" PN3 Page 7.

I have previously discussed the change in nursing assessment and consultation to focus on the medical and medication history. This change coupled with the increase of pharmacology knowledge gained through prescribing education is leading my participants to undertake medicine reviews with their patients.

" when you bring them in for medication reviews sometimes they do not know why they are taking things they could be taking them at the wrong time or they do not take enough of it and so without the information from the course I would not have the skills to really correct that" PN1 Page 2.

" when I started as a community matron I did start doing medication reviews but until we did the prescribing course I don't think we fully understood how far we could go" CM2 Page 6.

" I am a lot more confident in suggesting different regimes and approaches to medication" GN1 Page 7.

Medication reviews which, are an established role of the pharmacist, Krska, Cromarty, Arris et al.(2001), are being undertaken in the surgery by practice nurses and in the community by district nurses and community matrons for housebound patients. In a 2005 study Bradley et al reported only 3% of nurse prescribers considered medicines management skills important in prescribing. Whilst nurse prescribers in Bradley's study did not consider these skills important my data suggest that most nurse prescribers are using prescribing knowledge and skills to support medicines management activities. The most common activity identified was the medicine review although this was specific to nurses working in primary care settings. Medication reviews and medicine management roles in secondary care are mostly in the pharmacist domain. Unlike their primary care colleagues the participants from secondary care did not say that they were taking on medication reviews. This is most likely to be because my secondary care participants are specialist nurses who manage the treatment of a specific condition. Whilst they give advice and information for the medicines they prescribe for all other medicine activity the patient is referred to the GP or hospital consultant. According to Bradley et al (2005) roles in medicines management and medication reviews should be an integral part of nurse prescribing. My findings provide evidence to suggest primary care nurse prescribers are developing these roles but secondary care nurses are not. This finding has implications for practice as it raises questions about how nurses are using medicines knowledge to

support medicines management activities in practice. Nurses are the main administrators of medicines to patients and they are the second most common group of prescribing professionals. Their position in the division of labour as non-prescribers as well as prescribers is well placed for an active role.

A new division of labour has, been created to reflect a new jurisdiction of prescribing by nurses. This jurisdictional change has not only moved the boundaries between medicine and nursing but in the workplace also those of pharmacy and nursing. According to Abbott (1988) because jurisdictional control of tasks is limited to one or a small number of professions together the professions are part of an interdependent system of professions. He argued that "a move in one inevitably affects others" Abbott (1988 page 85). In this instance, there is no claim for jurisdiction of medicine review activities, just a shift to the actual division of labour. These smaller shifts between the prescribing professions and the prescribing and non-prescribing professions are likely to become more visible in the future. Changes to the division of labour will also need to occur as pharmacists, optometrists and allied health professionals integrate their prescribing roles.

4.3.7. Prescribing in practice: prescribing enhances nursing roles.

Participants viewed prescribing in practice as a positive addition to the role of the nurse. Participants took the opportunity, during the interview, to explain how nurse prescribing has enhanced their jobs, improved job satisfaction and for some enhanced their nursing role. These feelings of enhancement appear to derive from the autonomy prescribing allows in being able to complete episodes of care. As discussed in theme 1,

prescribing agreements nurse prescribers were happy to have a greater involvement in care activities.

"I think it has enhanced my role as a nurse and I went into nursing to be caring, look after patients and I hope I do that" PN5 page 11.

" it has actually boosted my role being a prescriber". HSP5 Page 7.

" it certainly makes a big difference how you feel about your job" CN2 Page 3.

"I have a lot more job satisfaction sometimes I got very frustrated because I knew what needed to be done but couldn't go any further..... it has actually enhanced my practice". WIC2 Page 9.

The views of my participants concur with those presented in previous research (Latter et al., 2004; Bradley and Nolan 2007) and add new evidence to illustrate how prescribing not only enhances but enables the development of nursing roles.

4.3.8: PRESCRIBING IN PRACTICE: Theme Summary.

Twenty one of my twenty six participants have effectively integrated prescribing into their practice and are prescribing for patients. The five who are not prescribing work in primary and secondary care settings. My participants gave examples of how they are using their prescribing skills and knowledge in a variety of healthcare settings, a testament to the acceptability of prescribing as a suitable role for nursing. The number of participants who are prescribing reflects the figures presented in the prescribing literature, Latter et al. (2004); Bradley et al. (2005). Reasons for not prescribing with exception of one illustrative case (PN 2) also reflect those previously reported. Computer generated prescriptions continue to be a barrier to nurse prescribing. Handwritten prescriptions are a viable

option in these situations however; the participants were reluctant to prescribe without automated computer checks for interactions and the recording of prescribed items. Patients accept prescribing by nurses and there is some evidence to suggest that patients benefit as nurse prescribers develop roles in medicines management. This was particularly prevalent in primary care nurse prescribing.

Participants described three approaches to starting to prescribe, as the situation arises, condition specific and individual specific. How nurse prescribers approach prescribing for patients has not been described previously in the prescribing literature. They show that systems of nurse prescribing do not always replicate those of medical prescribing. A series of factors influence the choice of approach. Specialist nurse prescribers who are prescribing a, limited number drugs, for a limited number of clinical conditions are more likely to prescribe as the situations arise. General prescribers who manage a wide range of conditions across all ages of the lifespan can find starting to prescribe difficult. For these nurses prescribing as the situation arises can be daunting and prescribing is managed by limiting prescribing to treat specific conditions or limiting prescribing to individual patients. These restricted forms of prescribing are not seen in medical systems of prescribing.

4.3.9: CHAPTER SUMMARY : Discussion and Findings.

I have presented in this findings and discussion chapter, three themes, prescribing agreements, prescribing relationships and prescribing in practice. Considered in sequence, as they are here the three represent a process leading to the effective integration of prescribing in practice. Within each theme, there are factors which will individually and in combination

promote, hinder and prevent the integration of prescribing in primary and secondary care.

I have explored the claim for jurisdiction of prescribing by nursing drawing on Abbotts work *The Systems of Professions, an Essay on the Division of Expert Labor* Abbott (1988). Nursings' claim for jurisdiction of prescribing evolved from examples of everyday nursing practice. Where nurses discuss treatment options, give advice, supply under patient group directions and recommend drug therapies to medical prescribers. These activities are a workplace assimilation of prescribing activity. According to Abbott (1988) workplace assimilation allows a profession to delegate a crafted version of the task to another occupation or profession. In terms of prescribing I have taken the crafted version of the task described by Abbott (1988) to be where nurses use their knowledge and skills to make prescribing decisions. This crafted version enables patients to receive medicines in a timely manner without the formal requirement for nurse prescribing education. Nurses undertake the process of prescribing within their knowledge and competence but legal and professional responsibility for the prescribing decisions rests with the doctor. In this context, the delegating profession maintain jurisdiction by holding the theoretical knowledge associated with the task. The medical profession gave support to the nursing claim for jurisdiction of prescribing. Doctors continue to support nurses to develop theoretical knowledge to inform prescribing activities through their role as medical supervisor to prescribing students and generally in prescribing teams.

Whilst jurisdiction is established, a new division of labour must be agreed in practice for the nurse to integrate prescribing. There was little evidence of formal agreements for a new division of labour. Nurse prescribers did

not want to challenge the established hierarchy of professions in healthcare. Instead, they talked of their prescribing roles as complementary to medicine. Prescribing would help doctors to get the job done. My participants spoke of prescribing within their nursing role and explained how it enhanced their practice and the care they are able to give by prescribing for patients (Bradley and Nolan 2007; Jones and Jones 2007). The integration of prescribing in a new division of labour occurred differently in primary and secondary care. In primary care the agreements were mostly informal and made between doctors, nurses and the team. In secondary care the agreements were formal and usually involved senior doctors, pharmacists and managers. These arrangements delayed prescribing, caused frustration and in some cases prevented nurse prescribing.

Participants demonstrated a need to seek permission from doctors to prescribe and to ask doctors to check their prescribing decisions. The fact that nurses want to discuss their prescribing with doctors has to be seen as a positive development for effective collaborative and the promotion of safe prescribing. These forms of behaviour are a key factor in how nurse prescribers develop the doctor-nurse relationship. The case studies show evidence that nurse prescribing can lead to forms of intra professional territorialism between nurses who do and nurses who do not prescribe. To the participants this rivalry is both unexpected and unwelcome. There effect was one of annoyance and disappointment but not sufficient to stop the nurse prescriber from prescribing. Primary legislation and employers prescribing policies gave nurse prescribers the authority to prescribe but for some participants trust within the doctor-nurse relationship proved the deciding factor for the decision to prescribe.

The doctor- nurse relationship emerged from these case studies as the most important factor which will determine the integration of prescribing. The role of trust and respect in the doctor- nurse relationship has been identified in the literature but has not been explored as a determining factor for nurse prescribing in practice. This form of trust is specific to those involved and has a direct effect on how the nurse will manage the risk and responsibility of prescribing. Jurisdiction agreements are framed in trust and influence confidence and perceptions of competence. This fundamental need for trust in the nurse-doctor relationship overrides policy and authority. In the absence of trust prescribing will not take place.

For those participants who were prescribing Independent prescribing was the preferred type of prescribing. This finding is in contrast to findings previously presented in the prescribing literatures. The most likely explanation is that the lifting of restrictions to independent prescribing in May 2006 has given nurses greater opportunity to use their diagnostic skills. This change to the legal framework of non- medical prescribing appears to have had a significant impact on the types of prescribing used in both primary and secondary care. My findings describe three approaches to the integration of prescribing in nursing practice.

1. As the opportunity present
2. Condition specific
3. Individual specific.

The identification of three approaches contrasts with a medical system of prescribing which is familiar to the professions and public. Nurse prescribers have said that they are at times, overwhelmed by the complexity and accountability of prescribing for patients and adopt a

restricted or staged approach to manage the risk of prescribing. Although restricting or staging was not part of their initial training these nurse prescribers are integrating prescribing cautiously, doing as the Department of Health and NMC expect by working within and developing their competence. According to Weiss and Sutton (2009) self restriction by new prescribers promotes a culture of safety in prescribing practice. My participants used doctor checking to promote patient safety and help them to integrate new prescribing knowledge with expert levels of professional knowledge. Yet they are criticised for being cautious and lacking confidence (Latter et al., 2004).

Nurses are integrating prescribing knowledge, new skills in medicine and medical history taking into nursing practice. The new skills build on existing communication skills in nursing (Latter et al., 2004; Bradley et al., 2005) to support nurse prescribing. A particularly interesting finding from these case studies is that prescribing knowledge is integrated and used in nursing practice regardless of whether the nurse prescribes in practice or not. It is clear from the patient literature on prescribing that patients expect prescribers to provide information about the medicines prescribed. Prescribing knowledge and skills have expanded nursing roles in medication reviews. These activities meet the needs of patients for information about the medicines prescribed expressed in prescribing literature by Berry et al. (2006) they also step into tasks associated with the role of the pharmacist.

CHAPTER 5: CONCLUSION.

Throughout my study, I had looked to individual and context specific factors, which would affect the integration of prescribing. Out of three themes, prescribing agreements, prescribing relationships and prescribing in practice a new pattern emerges. The integration of nurse prescribing in primary and secondary care can be, seen as the actions of individuals but these actions are best, explained as a response to the effect of professional and social systems.

5.1: The Integration of prescribing in professional systems.

Prescribing was, until the late 1990's an activity restricted by law to doctors, dentists and vets. The starting point for Abbott in his study of professions was, to question what professionals do and he spent his time, mostly in hospitals, watching what professionals actually do, Macdonald (1995). The claim for jurisdiction of prescribing for nurses was in part successful because nurses were already doing prescribing, albeit in a limited form. Abbott argued that in the workplace, inter professional division of labour is replaced by an intra organisational division of labour. In effect this means that the standard division of labour, which respects traditional activities of the professions, is replaced by an actual division of labour which reflects who actually undertakes the activities in the workplace. In Abbott's system of professions, the boundaries of jurisdiction between professions are more likely to be, replaced in "overworked worksites", Abbott (1988 p65). The need to get the job done, to maintain an effective flow of patients through the healthcare system requires healthcare professionals to adapt the standard or traditional division of labour. Whilst an actual division of labour gets the work done the standard division of labour remains the formal definition of jurisdiction between the

professions. When doctors and nurses are asked to identify the difference between their roles they refer to traditional roles and responsibilities reflecting the standard division of labour and not the actual division seen in the workplace.

Nurse prescribing was a formal change to the jurisdiction of prescribing that in effect removed the cornerstone on which medicine distinguished itself from other healthcare professions. Medicine had for a long time, shared the jurisdiction of prescribing with dentists and vets. Sharing with nurses was different because nurses would prescribe in the same workplace and most likely for the same patients. The participants in these case studies did not consider the acquisition of prescribing to be a challenge to the hierarchy of the medical profession. It had been important to these participants to state their position and to align their prescribing role as complementary to the role of the medical prescriber. Several were keen to make the point that they were nurses who prescribe and not doctors. Within this changing division of labour participants had talked about a developing collegiality in their doctor – nurse relationships. The move opens opportunities for nurses to enhance nursing practice and to build professional relationships with doctors through collegial work. This was shown through shared decision making at patient levels and medicines management discussions at practice level.

One of the key findings from this study was that many independent and supplementary nurse prescribers seek permission from the doctors they work with before prescribing for a patient. This activity was, found to occur mostly in primary care where agreement for a new division of labour was, left to the doctor and prescribing nurse. For nurse prescribers permission seeking took the form of a polite and respectful request to the doctor for

permission to prescribe a specific item for a named patient. The action is a way for the nurse to clarify where accountability and responsibility for prescribing decisions lie in the new division of labour. The nurse prescriber takes accountability for the prescribing decision but permission seeking acknowledges that overall responsibility for the patient remains with the doctor. Permission seeking enables the nurse prescriber to demonstrate professional respect and avoid any potential conflict of agreement about the division of labour with the doctor. Where these agreements are, established by the employing organisation the need for doctor-nurse negotiation of the division of labour is, averted and permission seeking behaviour is not seen. By prior agreement at an organisational level or by permission seeking approaches in prescribing teams the boundaries of a new division of labour are established and the hierarchy of the medical profession maintained (Fisher 2005).

The participants of the case studies did not describe nurse and non-medical prescribing as a challenge to the hierarchy of medicine, but a challenge to assumptions made about the exclusivity of prescribing knowledge. Doctors warned nurses through research and the professions press that, they might not have developed sufficient theoretical prescribing knowledge to support safe prescribing. This theoretical or "abstract knowledge", Abbott (1988 p55) of prescribing related to diagnosis and prescribing is integral to, and embedded within the professional knowledge of medicine. Whilst the medical profession appear willing to help nurse prescribers to develop this knowledge, it is difficult to define in exact measures the knowledge required for safe prescribing. Abbott (1988) explains that when a profession gains jurisdiction the task they gain is, at first defined by the previous holding profession. This would mean that the task of prescribing is defined by the medical profession, based on their theoretical knowledge

and interacting with other professions in the system of professions in a context of medical prescribing. Having secured jurisdiction of prescribing nursing seeks to embed this medically defined and practiced task into nursing.

Abbott (1988) uses the terms objective and subjective tasks to explain how this can, be achieved. He proposed that tasks have objective and subjective qualities. Objective qualities simply tie tasks together and I have taken this to mean that the task of prescribing has ties to the task of diagnosis. It is this tie, which defines the curative element of prescribing. The profession currently holding jurisdiction of the task constructs subjective qualities of a task. If, as Abbott argues, tasks have both subjective and objective qualities, moving jurisdiction of prescribing into nursing moves the task of diagnosis into the objective tasks of nursing. This specific activity takes nursing practice closer to the cure roles associated with medical practice.

For nurse prescribers the task of prescribing is not undertaken at the expense of or in place of care activities. Consistent with findings from previous studies (Bradley et al., 2005) my participants were not concerned that prescribing would replace their caring role. The objective qualities of prescribing have enabled nurse prescribers to complete episodes of care and enhance the care role of nursing. Witz (2002) has argued that nursing seeks to renegotiate elements of medical subordination and provide nurses autonomy in the planning, delivery and evaluation of nursing care. Nurse prescribing provides opportunities for nurses to achieve this aim.

Subjective qualities are, said by Abbott to be, "imposed by the present and past culture of the task" Abbott (1988 Page 36). If nurse prescribing was to

be framed to public, political, and professional expectations of medical prescribing nursing would fully adopt the established medical system of prescribing. Nurse prescribers in these case studies were keen to emphasize the nursing component of their prescribing role. Attempts to define the task of prescribing in nursing should reflect a new division of labour in which the nurse has autonomy to prescribe and is therefore accountable and responsible for the decision to prescribe. One way in which nurse prescribers start to define the task of prescribing in nursing roles is shown in how they approach the integration of prescribing in nursing practice. In a medical system of prescribing, the doctor prescribes for patients as they present for treatment and will seek advice from colleagues or refer as and when necessary. With no published evidence to suggest otherwise, it is reasonable to assume public and healthcare professionals will expect nurse prescribers to follow this established medical system of prescribing. Some nurse prescribers, most commonly those working in specialist roles take the medical systems approach to prescribing. However, many nurse prescribers will start prescribing for patients after first imposing restrictions to their own prescribing practice.

These case studies describe three approaches to the integration of prescribing in primary and secondary care nursing practice. The first approach uses the medical system of prescribing described above. Nurse prescribers prescribe where and when patient need dictates. Nurse prescribers taking this approach usually work in narrow fields of specialist practice mostly in secondary care but often with joint primary and secondary care responsibilities. In specialist roles the range of clinical conditions and drug therapies they will prescribe for are limited.

In the second and third approaches to the integration of prescribing in practice, nurse prescribers were found to impose restrictions on their prescribing. These restrictions take two forms. In approach 2, condition specific, the nurse will prescribe for groups of patients. For example, patients who present with minor illness or patients who attend the asthma clinic. In approach 3, individual specific, the nurse prescribes for patients they know. Nurse prescribers who take approach 2 or 3 were most likely to be working in general nursing or caring for elderly patients with complex conditions and co morbidities. These nurses provide care to patients throughout the lifespan or towards the end of life and are often involved in the treatment, prevention and symptom control of acute and chronic conditions. Their care responsibilities are broad and far ranging. To integrate nurse prescribing in nursing practice a prescribing nurse must accept the accountability and responsibility for the objective ties of diagnosis and prescribing. Nurse prescribers who take approaches 2 or 3 are working in general areas of nursing care and often in new nursing roles. They can feel overwhelmed by the autonomy and opportunity that prescribing authority allows them.

The integration of prescribing is initially about accepting and managing the accountability and autonomy of prescribing whilst building new prescribing knowledge into existing nursing knowledge. By taking a condition or individual specific approach, the nurse is able to manage the risk in terms of accountability and responsibility which prescribing autonomy presents. The outcome of effective integration is that it enables nurses to complete episodes of care, to enhance the care they offer patients and improve the satisfaction they feel about their job. In defining the task of prescribing within the nursing role the division of labour is redrawn. As nurses start to use their prescribing knowledge within nursing practice they take

advantage of the autonomy prescribing authority affords them. Prescribing experience builds over time and as confidence, competence and knowledge develop, the initial restrictions imposed by the approach are, in part or completely lifted.

Findings from these case studies confirm previously published statistics, which show approximately 1 in 5 nurse prescribers are not prescribing for patients. By looking in detail at each case I was able to add contextual detail and investigate why each of these nurses was not prescribing. The reasons given were varied but the most common element identified was a perceived lack of trust or support from doctors or the employing organisation. There were other contributing factors, software problems, new roles with poor role clarity and a lack of confidence in prescribing knowledge being the most frequently cited. However, where the level of trust and support expected was not met the nurse prescriber felt unable to accept the accountability and responsibility of a prescribing role. The significance of trust in prescribing relationships is, explored later.

In contrast to published reports of nurse prescribing which describe large numbers of nurses using supplementary prescribing only one of my participants used supplementary prescribing arrangements. Given the autonomy to choose between independent or supplementary prescribing nurse prescribers have shown a preference for independent prescribing. It is useful to remind ourselves that the key difference between independent and supplementary prescribing lies with the responsibility and accountability for diagnosis. Earlier I explained the significance of diagnosis as an objective task of prescribing and explored how accepting accountability for prescribing decisions influenced a nurse's approach to the integration of prescribing. The most obvious solution to the problem of

diagnosis for nurse prescribers who lack confidence or competence in diagnosis would be to prescribe under supplementary prescribing arrangements. Supplementary prescribing has been presented in the prescribing literature as a method through which non medical prescribers can work in partnership with doctors to build their prescribing confidence (Courtenay and Carey 2008). Under supplementary prescribing, the doctor is responsible for the diagnosis DH (2005). Nurse prescribers in these case studies of primary and secondary care shun supplementary prescribing stating their dislike of the administration requirements of clinical management plans.

Instead, those who lacked confidence in their prescribing role sought support and advice whilst using independent prescribing arrangements. The level of dependence on doctors found in these case studies was greater than that reported in previous prescribing studies (Courtenay et al., 2004; Rodden 2001). I provide evidence to suggest that doctor dependence within the first year of qualifying as a nurse prescriber has become more widespread since the Department of Health opened the formulary for independent nurse prescribing in 2006. In lifting these restrictions, diagnosis has to be fully integrated into the objective tasks of nursing (Abbott 1988). With such a wide remit of prescribing open to nurses it is possible that there are gaps in the theoretical knowledge nurse prescribers are expected to have before commencing prescribing education (NMC 2006).

The suggestion gains additional support from an exploration of nurse prescriber roles. Prescribing policies had, at first restricted nurse prescribing to dressings and topical agents. Over an eight year period prescribing policies evolved to allow nurse prescribing of all licensed and

unlicensed medicines. These policies developed alongside new organisations of healthcare delivery, many of which placed nurses in case manager roles for patients with chronic diseases or as first contact practitioners in situations previously under medical jurisdiction. Nurses taking on these new roles frequently find themselves working beyond traditional boundaries of nursing in a new division of labour. My findings support the view that being able to prescribe is essential in these new roles and that the potential to prevent hospital admissions is starting to be realised. In these new roles nurse prescribers are prescribing beyond the initial expectations of a nurse prescriber who would use prescribing to enhance a traditional nursing role. Nurse prescribers in 2009 are expected to prescribe to prevent ill health, to treat minor and acute illness and to control the lifelong symptoms of living with long term conditions. For the majority of the participants being able to prescribe reduces the professional frustration associated with a lack of autonomy over patient care. Prescribing makes the job easier and increases job satisfaction but prescribing is not essential to traditional nursing roles. The autonomy of prescribing has the effect of enhancing traditional nursing roles. In extended nursing roles mostly created in new organisations of healthcare services nurse prescribing is essential part of the nurses role.

In Abbott's system of professions (1988) the claim by nursing for jurisdiction of prescribing was not a full claim. It was in effect a claim for shared jurisdiction of prescribing with medicine and other non-medical professions. Whilst the success of the claim results in a new division of labour and enhances nursing practice it has little influence on the professional status of nursing, medicine or any of the other non- medical prescribing professions. Prescribing activities taken by nurses follow the assimilation previously at play in the workplace and is therefore not

entirely new. Prescribing by proxy as an assimilated workplace version of prescribing will continue to hold a place in clinical practice. In his work Abbott (1988) presents the idea that workplace assimilation is a method by which the dominant profession will maintain control of the delegated task and underpinning theoretical knowledge. To me the restrictions of workplace assimilation were more about the legal framework for the prescribing, supply and administration of medicines and less about the medical profession protecting its roles. It is however interesting here to follow Abbott's argument in the context of prescribing jurisdiction. The medical profession supported nursing in its claim for jurisdiction, Jones (1999). There are a number of plausible explanations to support, defend and justify this action. However, the fact that they gave support was important to a positive outcome for the claim. According to Abbott (1988) the dominant profession seeks to control the delegated task. It can be, argued that the medical profession have authorised, coached and overseen the development of non-medical prescribing policy. It can be, argued that the prescribing nurses and other non-medical prescribers will take on the routine prescribing work of doctors. Abbott argued that routine work is dangerous to dominant professions because defending these boundaries against involvement by many professions is distracting. In delegating routine prescribing medicine is, left free to maintain its boundaries and defend a position in the hierarchy of healthcare professions. Following Abbott's argument through leads me to suggest, that if nursing or any of the other non medical profession with authority to prescribe make mistakes medicine will reclaim its monopoly of prescribing. Should this happen it would in turn strengthen the control of the medical profession over prescribing and their position as a dominant profession. In Abbott's system of the professions medicine have little to loose in sharing jurisdiction of prescribing with other healthcare professionals.

5.2: The Integration of Prescribing and a Social System of Trust.

The importance of trust in doctor-nurse relationships is mentioned in the literature but its inclusion is generally unremarkable (Pullon 2008). By describing how the integration of nurse prescribing is prevented when trust is absent or not established in the doctor-nurse relationship trust is shown to be important. Trust is part of our everyday lives, trust guides our actions and the decisions we choose to make. These decisions are, based in part on the expectations we have of others. Expectations are a defining element in lay and sociological presentations of trust. Confidence guides our expectations of trust, the confidence we have for example, that our expectations will be met (Luhmann 1979). A decision to trust is, based on the likelihood of others behaving in the way we expect them to behave. My findings suggest that an established doctor-nurse relationship is a good foundation for the integration of nurse prescribing. Descriptions show that getting to know each other provides doctor and nurse answers to questions of competence, of specialist knowledge and of clinical boundaries beyond which the nurse will refer. Prescribing moves the clinical role of the nurse prescriber beyond the expected roles of a nurse. According to Abbott workplace assimilation is facilitated by the fact that professions are not homogenous groups Abbott (1988 p66). He argued that it is the real output of an individual which matters in the actual division of labour. My findings suggest this may be so and by getting to know each other and establishing relationships the acceptability of the new role for the nurse within the division of labour is agreed. Once the role of the nurse prescriber in a new division of labour is agreed trust in the relationship is further strengthened through reciprocity and collegiality

Where trust was absent, the integration of prescribing was, directly affected. The prescribing nurse in these situations chose either not to prescribe at all or not prescribe for patients under the care of that particular doctor. It is clear from my participant descriptions that nurse prescribers understand the accountability and responsibility associated with the autonomy to prescribe. In the absence of trust mistrust develops, as the nurse is prescribing within a team he or she is unprepared to take a risk on trust and prescribing does not occur. In the presence of trust, the integration of prescribing in practice is, supported. Trust in prescribing relationships was a significant finding that raises an issue reported in the literature but not previously explored in any detail.

5.3: The Effective Integration of Nurse Prescribing in Primary and Secondary Care.

Throughout my study, I had looked to individual and context specific actions to determine the integration of prescribing. Three themes developed from the data, which suggested that the integration of nurse prescribing in primary and secondary care can, be explained by individual actions but that these actions are determined by professional and social systems in the workplace.

Social and professional systems define the legal and professional boundaries of jurisdiction for prescribing by doctors and the non-medical prescribing professions. In achieving jurisdiction of prescribing nurse prescribers must integrate the objective tasks of prescribing and diagnosis into nursing practice. According to Abbot this will be achieved by redefining the problem of prescribing within nursing. As part of the process to define the subjective task of nurse prescribing my participants described three approaches to integrate prescribing in nursing practice. The clinical role of

the nurse in the healthcare organisation and the professional, legal and social expectations of accountability each serve to influence the nurse prescribers approach. In order to achieve effective integration there needs to be commitment from the nurse prescriber the employing organisation and the doctors alongside whom the nurse will prescribe.

The shared jurisdiction of prescribing serves to maintain a medical hierarchy within the division of labour and the nurse prescriber must find a prescribing position within the prescribing team. In primary care settings these agreements are made within the team. In secondary care they are, made and agreed by the organisation for the prescriber. These case studies have shown that when trust is absent mistrust develops. This has been described, mostly in doctor - nurse relationships but also in the relationship between prescriber and healthcare organisation. The presence of trust in prescribing relationships determines the effective integration of nurse prescribing. In prescribing relationships trust is all or nothing, there are no half measures. In the presence of trust, the effective integration of prescribing in practice becomes enabled and supported. Where trust is absent mistrust developed and the integration of prescribing prevented. For some nurse prescribers mistrust prevented all prescribing for others it prevented prescribing within the mistrusted relationship.

5.4: What does this research add to nurse prescribing?

Two key findings emerge from these case studies of nurse prescribing in primary and secondary care. For the first time nurse prescribers described how they started to prescribe in practice. They described three approaches, as opportunities present, condition specific and individual specific. The first approach reflects the system of medical prescribing which is familiar to patients and professionals. Here the nurse prescriber will prescribe for

patients who present for treatment. In approaches 2 and 3 the nurse prescriber restricts prescribing to groups of patients presenting with specific conditions or will prescribe for individual patients known to them.

I suggest that the presence of trust in the doctor-nurse and nurse-employer relationships determines the integration of nurse prescribing. Although the professions literature highlights trust as important to healthcare practice, its determining role in the integration of prescribing was unexpected. In a reflection of the legal and professional responsibility of prescribing trust must be present for the prescriber to have the confidence to accept the accountability of prescribing for patients. Trust in prescribing relationships enables the integration of prescribing through support.

Locating this study in Abbott's System of Professions offered a new viewpoint to explore the claim by nursing for jurisdiction of prescribing. This research shows how nurse prescribing as a new division of labour aligns social constructs of professions and a traditional division of labour with the actual division of labour found in the workplace. Drawing on Abbott's work, 'A System of Professions', Abbott (1998) I was able to start my investigation from the actual division of labour, who did what in the workplace as opposed to a traditional reflection of professional roles. For Abbott the claim by nursing for jurisdiction is not a full claim for jurisdiction. From this viewpoint, it was possible to speculate how this claim for jurisdiction might affect the nursing and medical professions in the system of professions and explain the low conflict model of agreement presented in the literature and in these case studies (Allen 1997). Using this framework allowed an investigation of how a new division of labour is agreed and how once agreed, prescribing is integrated in nursing practice.

Using Abbotts' system of professions helped to maintain the focus of these case studies on the division of labour.

Trust in the doctor-nurse relationship was, found to be particularly important to the effective integration of nurse prescribing. Abbott's work does not address the issue of relationships between professionals or between professionals and their employer in a division of labour. I therefore turned to consider the question of trust as a social concept using the work of Luhmann (1979). Common attributes of trust apply equally to the doctor – nurse relationship as any other situation of trust in relationships. The accountability and responsibility of prescribing authority adds weight to the importance of trust in the doctor-nurse relationship. In the absence of trust, mistrust is established and the integration of nurse prescribing prevented. The prescribing and professions literatures, acknowledge the need for trust in working relationships but have not explored trust in prescribing relationships. Trust is embedded in social and professional systems and, where established, forms the basis for agreements to integrate prescribing in a new division of labour. Nurse prescribers have legal, professional and employer authority to prescribe and yet nurse prescribers seek permission from doctors before prescribing for patients. In these trusting relationships, nurse prescribers used doctor checking activities, to confirm the legitimacy of trust placed in them by the doctor and to build prescribing confidence through reciprocity and collegiality.

5.5: Key issues.

My study has shown that what at first appeared to be individual factors affecting the integration of nurse prescribing are actually professional and social systems, which determine prescribing integration.

Nurse prescribers take one of three approaches to integrate prescribing into practice. The first approach adopts a medical system of prescribing. In the second and third approaches the nurse prescriber restricts his/her own prescribing by clinical condition or to individual patients. As the length of time and prescribing experience increase, the restrictions are, in full or part removed.

There are differences in the way primary and secondary care organisations manage the integration of nurse prescribing. Secondary care organisations determine the parameters of nurse prescribing on behalf of nurse prescribers. Primary care nurse prescribers negotiate parameters of prescribing with the prescribing team.

Independent prescribing was the preferred method of prescribing for nurses working in primary and secondary care. Nurses took advantage of good doctor – nurse relationships to support prescribing decisions where the nurse lacked confidence. This support took the form of doctor checking activities.

Trust in relationships between doctor and nurse and nurse-employer determines the integration of nurse prescribing. The absence of trust prevents nurse prescribing.

5.6: Recommendations for Practice.

Following the successful completion of prescribing education, nurse prescribers are expected to integrate prescribing and prescribe for their patients. These case studies have described how nurse prescribers approach the integration of prescribing in both primary and secondary healthcare settings. Within these descriptions nurse prescribers have identified factors that hinder, promote and prevent their prescribing. The most significant of these factors was, found to be the doctor – nurse and nurse- employer relationship. The presence of trust within these relationships determines the effective integration of prescribing. As I have identified above nurse prescribers are expected, once qualified to prescribe for patients. These case studies of primary and secondary care have investigated how and why nurse prescribing is integrated. Findings from this study have implications for practice and my recommendations for practice intended for use by nurses, employers and prescribing educators.

5.6.1: Recommendations for nurse applicants to prescribing courses.

- Nurse prescribing is not an activity suitable for all nurses. Nurses considering prescribing education have a responsibility to think about themselves as prescribers and their future prescribing role. Nurses who are able to identify a prescribing role and honestly believe they are academically able to study at level 3 should be encouraged and supported by healthcare employers to apply.
- Potential applicants should carefully consider the requirements for entry set by the NMC (NMC 2006). Particularly, in relation to diagnostic skills in the area of practice within which the prescriber

will be expected to prescribe. According to the NMC the nurse should have these skills prior to commencing prescribing education. Where a learning need is identified, the future prescriber should seek to meet these needs through formal and informal education routes.

- Potential applicants to prescribing courses should think about the team(s) within which they will prescribe. Do team members have knowledge of nurse prescribing, are they generally supportive of non- medical prescribing. What might the team expect of the nurse prescriber. If the expectations are unrealistic the situation might be resolved through discussion. Where this is not possible prescribing once qualified is likely to be negatively affected.
- Potential applicants should think about the relationship they have with doctors alongside whom they will prescribe. Nurses should ask themselves if trust is present within the relationship. If it is not they should consider if trust can be built during the programme of education. If it cannot the nurse should delay prescribing education.

5.6.2: Recommendations for Healthcare Organisations

New nurse prescribers.

- Newly qualified nurse prescribers individually or in groups should enter into communication with a manager. Ideally, this would be a face to face meeting but could otherwise take the form of email or telephone contact. This could be with a line manager or the prescribing lead depending on the management structure of the organisation. The contact should take place during the period

between the student receiving notification of results from the university and receipt of a new statement of entry from the NMC.

- Nurse prescribers should be given a copy of or, directed to a copy of the local prescribing policy within which they are expected to practice. Where necessary the organisation process for authority to prescribe should be explained. It is, expected that restrictions or additional requirements of the organisation are likely to be in place for clinical governance purposes. These should be, clearly explained to new prescribers and the expected length of time before prescribing is likely to be authorised given. The manager should explain any speciality specific restrictions to prescribing and the prescriber given an opportunity to ask questions.

- Nurse Managers should recognise that not all nurses wish to become prescribers. These nurses must be supported in their decision and offered in house education and development to ensure their knowledge of medicines is appropriate to their role in advising other prescribers and educating patients about the medicines they are taking.

- There are likely to be nurses who do not wish at that particular moment in time to take on the responsibility of a prescribing role but may do in the future. These nurses should be encouraged to inform their managers when they feel the time is right for them to enter prescribing education. In the interim should participate in house education and development to ensure their knowledge of medicines is appropriate to their role in advising other prescribers and educating patients about the medicines they are taking.

Support Mechanisms

- The organisation should have in place a lead person whom a nurse prescriber can contact with questions or queries. This might be a manager but equally could be a pharmacist or experienced nurse prescriber.

- Large healthcare organisations require a lead for non medical prescribing. This person should be a manager with a position in the organisation to take a strategic lead to the development and support of non medical prescribing. In addition, there should be a prescribing lead in practice. This person should be the point of contact prescribers who need to clarify a particular issue or seek support.

- Trust is a determining factor for the integration of prescribing in practice. The actions identified above will go some way to establishing what the employing organisation expect of the prescriber. Trust is, also enacted through support. I am aware that organisations have worked hard to establish prescribing forums and support groups for nurse prescribers. I commend organisations that have these mechanisms in place and urge those who have not to look to providing this support service.

- Healthcare organisations should be aware that nurses do not always follow medical approaches to prescribing. There are, three ways in which nurses commonly approach prescribing in practice. In the first, the nurse prescribes for patients as they present. This replicates the medical approach to prescribing. In the second

approach, the nurse will restrict prescribing to groups of patients or specific conditions. For example a nurse running asthma, diabetes and coronary heart disease clinics may choose to prescribe at first in only the asthma clinic. In the third approach, the nurse restricts prescribing to individual patients. The client group for these nurses have complex conditions and co morbidity. Nurses will begin to prescribe for patients when they are familiar with the past medical and medication history and perhaps the patient's conditions are stable. In order for healthcare organisations to support nurse prescribers they should be aware that nurses approach the integration of prescribing in different ways and not automatically the approach adopted by medicine.

- For those nurse prescribers who choose to restrict initial prescribing the annual review of performance mechanism can be used to support the development of prescribing activity. At the review, learning needs and systems of support can be, identified and put into place to enable the prescriber to extend prescribing knowledge and skills and remove previous restrictions.
- Nurse prescribers use their prescribing knowledge to undertake medicine reviews and to advise patients about their medications. These activities have the potential to prevent hospital admission because of polypharmacy causing unwanted side effects and potential drug interactions. Prescribing knowledge is, used in this way whether the nurse does or does not prescribe. Where these activities are being undertaken by non prescribing nurses they should be supported by the organisation be working to a prescribing policy and have access to an up to date BNF. This finding raises questions about the role of the non-prescribing nurse and medicine

reviews. Organisations should consider the opportunity to provide all nurses basic knowledge of pharmacokinetics and pharmacodynamics sufficient to understand side effects and drug interactions. This could be, offered in house with the expected outcome of preventing ill health and reducing hospital admission. Working relationships between nurses and pharmacists can be, strengthened to support this role.

- Non-Nurse prescribers should be part of decisions about who in the team will undertake prescribing education and why. Organisations should continue in their efforts to backfill the posts of those entering prescribing education in order to reduce the workload impact of a nurse on the prescribing course.

5.6.3: Recommendations for Higher Education Institutions.

- The three approaches to prescribing should be, taught to student prescribers within the 'prescribing in teams' indicative content and learning outcome. This will give students who are unsure of where to start a strategy they can use for guidance.
- During the process of medically supervised practice nurse prescribing students should be encouraged to think about how they might approach prescribing in their practice. They should talk to the doctors and nurses in the prescribing teams.
- Student prescribers working in new teams or new roles should be encouraged to build trust with the doctors they will be prescribing with once qualified. These relationships can, be developed during the process of education.

- Student prescribers should be encouraged to talk to doctors about how they will approach prescribing and where restricted approaches are chosen to communicate this to the team.

- Prescribing students should be encouraged to acknowledge the role of permission seeking and doctor checking activities.

- The role of doctors in the supervised practice element of prescribing education should continue and for independent and supplementary prescribers the role should not be, undertaken by nurse prescribers.

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Interview Schedule

Personal

- Participants name
- Title / Role.
- How long have you been working in this role
- Can you briefly describe how you use prescribing in your everyday practice.
- You were qualified and able to prescribe from can you recall when you actually began prescribing?
- *If this was not within the expected 3-6 months – ask participant to identify what caused the delay.*
- Tell me about the time when you began to think about using nurse prescribing in your practice
- How did it feel to write your first prescription?
- How do you feel about undertaking an activity which was formerly a medical role?
- How do you feel about prescribing now?
- Think back to your work before you came on the prescribing course, has your practice changed, can you describe how it has changed.
- Did you find it difficult to begin prescribing for your patients, tell me about how you approached this.

Organisation

- Has prescribing required you to change the way you organise your work?
- Who has been involved in decisions about what and how you prescribing.
- *Have your employers played a part in deciding the boundaries of, or influencing your prescribing practice.*
- How do you think the organisation see nurse prescribing?
- How often do you refer to local or national guidance or protocols when you prescribe?
- Give examples of those you have used in prescribing recently
- Tell me about how you use them, is it in the same way as it was before you qualified as a prescriber.

Education and Support

- As a nurse do you feel adequately prepared and supported to undertake an activity which was formerly the role of the doctor?
- Is there any education or support you feel should be available to qualified nurse prescribers.

Appendix 2.

Table to show recruitment of study participants by time.

	Invitation Jun 2007	July 2007	Sept 2007	Oct 2007	Nov 2007
1	PN27				
	PN25	PN25			
	PN31	PN31			
	PN35	PN35 Recruited			
	GN1	GN1			
	GN2 Recruited				
		PN26 Recruited			
		CN6	CN6		
		PN30	PN30		
				CN5	
				PN23 Recruited	
			MH12 Recruited		
	Jun 2007	Jul 2007	Sept 2007	Oct 2007	Nov 2007
2	PN19	PN19			
	CM 7	CM 7			
	NSP2 Recruited				
	NSP30				
	MW 6 Recruited				
	CN3 Recruited				
		CM 2 Recruited			
			NSP27	NSP27	
			NSP21		
			CM6 Recruited		
			MW4 Recruited		
			CN4 Recruited		
				NSP26 Recruited	
	Invitation Jun 2007	Jul 2007	Sept20 07	Oct2007	Nov 2007

3	PN15				
	HV 2 Recruited				
	NSP 1 Recruited				
	NSP 17	NSP 17			
		PN11	PN11		
		PN19 Recruited			
			PN18		
			NSP10	NSP10	
			PN12	PN12	
			PN13 Recruited		
			PN16	PN16	
			CM4		
			NSP14 Recruited		
	Invitation Jun 2007	Jul 2007	Sept20 07	Oct2007	Nov 2007
4	PN9 Recruited				
	DN1 Recruited				
	NSP7 Recruited				
	NSP 8				
		WC 3 Recruited			
		WC 2 Recruited			
			CM5 Recruited		
			PN3	PN3	
			NSP5	NSP5	
			PN5	MH6	
			NSP 31	NSP 31	
			NSP32	NSP32	
				MH4 Recruited	
				CM7 Recruited	

Case Studies in Nurse Prescribing – Version 1- 5th March 2007 – 07/Q2401/4



Research Title: Case studies in Nurse prescribing.
Researcher: Dianne Bowskill.

Poor or Dangerous Practice – Proposals for Action.

In the unlikely event that poor or dangerous practice is identified or disclosed by the participant the following action will be taken. A staged response is proposed and the researcher will use professional judgement at all times.

Staged Response

Level 1: Poor practice.

The researcher will talk to the practitioner, identify the action considered poor practice and discuss acceptable and appropriate prescribing practice.

Level 2: Practice considered a potential risk to patients.

The researcher will talk to the practitioner, identify the action considered poor practice and discuss acceptable and appropriate prescribing practice. Discuss clinical competence in terms of accountability for prescribing practice and identify any training need.

Level 3: Actual and immediate risk to patients.

The researcher will stop the interview and inform the participant of the concern. The participant will be told that the disclosure will need to be acted upon. The researcher will inform the participants line manager of the disclosure.

Appendix 4.

Dianne Bowskill
Lecturer.
Lead Non- medical Prescribing
dianne.bowskill@nottingham.ac.uk
011582 30934

20th November 2007.

Dear

You are being invited to take part in a nurse prescribing research study to be undertaken by Dianne Bowskill at the University of Nottingham. The research is part of an academic award and will be conducted under the supervision of Professor Veronica James and Dr Steven Timmons from the School of Nursing.

Under the title '**the integration of nurse prescribing; case studies in primary and secondary care**' the research aims to identify how nurses accommodate prescribing in their nursing practice. Further details can be found on the participant information sheet enclosed. This information sheet explains why the research is being undertaken and what it involves.

Please take a little time to read this information carefully. If you have any questions or would like further clarification please contact me by telephone or email (details above.)

Participation is entirely voluntary and you can withdraw at any time. If you are willing to be interviewed please either return the pink slip back to me by post, or telephone / email your agreement on 0115982 30934 dianne.bowskill@nottingham.ac.uk.

regards,

Dianne Bowskill



Participant identification number:.....

Date:.....

The integration of nurse prescribing; case studies in primary and secondary care.

Participant Information Sheet.

You are being invited to take part in a research study. Before you decide whether to participate it is important that you understand why the research is being undertaken and what it will involve. Please take a little time to read this information carefully and ask for more information about anything that is not clear.

Nurse prescribing is being used in a wide variety of nursing roles in both primary and secondary care. This research will invite 24 nurse prescribers to describe how they have taken prescribing and made it work in their individual area of practice. The cases are chosen to represent two time frames, 12 cases will have been qualified to prescribe for a period of 3 to 6 months and a further 12 qualified to prescribe for 12 to 18 months.

Findings from this study will enable us to describe how nurses integrate prescribing in a variety of clinical care settings and identify if time prescribing and prescribing experience play any part in the way it is used. It will add to prescribing research and inform the educational preparation and professional development of prescribing nurses.

Why have I been chosen?

You are one of the 138 nurses at the University of Nottingham to qualify as a nurse prescriber between September 2005 and September 2006. Students who qualified during this period are individually chosen to represent prescribing students under three key areas of interest, nursing role, primary or secondary care and employer.

What do I have to do?

If you choose to participate in this research you will be asked to talk about your experience of prescribing in your practice area. The interviews should take no longer than one hour and will be recorded on audio tape. It does not matter if you have not yet been able to prescribe or only occasionally prescribe I am still interested in hearing about your experience.

If you wish to take part in the study please return the slip provided or alternatively you can contact me by telephone on 011582 30934 or email

dianne.bowskill@nottingham.ac.uk. I will be conducting the interviews which will take place where you work. If you are happy to take part I will contact you to arrange a convenient interview date and time. I will also contact you one working day prior to the interview to confirm arrangements. It is expected that you will be asked to participate in one interview, the interview will not involve patients or require access to patient records or any other patient specific information.

Will my taking part in the study be kept confidential?

Each participant will be allocated a number and all information collected will be kept strictly confidential. Anonymised direct quotes from the interview may be used in the study report, presentations or publications. However, in the event of dangerous practice being disclosed to me I am obliged by my professional code of conduct to take appropriate action. Please see page 2 for further details.

What will happen to the results of the research?

This research is undertaken for doctoral academic study. When the data is analysed the research will be written for academic review, journal publication, conference presentation and discussion at local and national prescribing forums. It will not be possible to identify you from the written report or published works. At the end of the study you will be invited to attend a presentation at the University of Nottingham. A summary of research findings will also be made available.

What are the benefits of taking part?

There will be no personal benefit to taking part in this research. However, information gathered and theory developed from the study will enhance the knowledge and understanding we have of nurse prescribing. It is hoped that this may help us to understand how prescribing, formerly a medical role is adopted by the nursing profession. It may also highlight education and support needs of nurse prescribers.

Who has reviewed the study?

The study has been given a favourable opinion for conduct within the NHS by the Derbyshire Research Ethics Committee.

What if there is a problem?

If you have a concern about any aspect of this study you should ask to speak to the researcher in the first instance, Dianne Bowskill telephone 0115 82 30934 or her supervisor Professor Veronica James telephone 0115 82 30814. If you wish to make a complaint you may contact

Research Governance Manager
Research and Development Office
Clinical Sciences Area
University of Nottingham Medical School at Derby
DE22 3DT
Tel: 01332 724712.

In the unlikely situation where practice considered is considered to be bad or a risk to patient or public safety is identified during the interview the researcher will stop the interview and inform the participant of the

disclosure. The researcher will act in accordance with the Nursing and Midwifery Council Code of professional conduct: standards for conduct, performance and ethics 2004.

If you would like further information, please contact me

Dianne Bowskill

Lecturer

Non Medical Prescribing Lead.

University of Nottingham

School of Nursing

Queens Medical Centre

Nottingham

NG7 2UH

Tel: 011582 30934 / 011582 30850.

dianne.bowskill@nottingham.ac.uk

This research is part of a study leading to the qualification Doctor of Health Science.



Study Number: 07/Q2401/4

Participant Identification Number for this Study:

CONSENT FORM

Title of Project: The integration of nurse prescribing; case studies in primary and secondary care.

Name of Researcher: Dianne Bowskill.

Please initial the box

1. I confirm that I have read and understand the information sheet dated 17/04/02007 (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free To withdraw without giving reason, without my legal rights being affected.

3. I understand that relevant sections of any of my data collected during the study, may be looked at by responsible individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research I give permission for these individuals to have access to my records.

4. I understand that the researcher may use anonymised direct quotes from the interview in the study report, presentations or publications.

5. I agree to take part in the above study.

Name of Participant..... Date.....

Signature.....

Name of Person taking consent Date.....
Signature (if different from researcher)

.....
Researcher Date.....
Signature.....

Appendix 7.

PI No	M/ F	Age GP	Pri / Sec	Role	Time post	Int date	Presc from	Began pres	month
PN1	F	32-42	P	N Prac	3.5 yr	9. 2007	8. 2005	8. 2005	24m
PN2	F	43-53	P	Prac N	17yr	8. 2007	8. 2005	8. 2005	24m
PN3	F	43-53	P	Prac N	18yr	11. 2007	8. 2005	9. 2005	26m
GN1	F	43-53	P	N cons	6.5yr	6.2007	8. 2005	Not pres	24m
MH1	M	43-53	P	Mental Health	5yr	11. 2007	8. 2005	10. 2005	25m
NSP 1 HF	F	32-42	P	Heart Failure	1.2yr	6. 2007	11. 2005	Not pres	20m
CN1	F	43-53	S	Urol child	17yr	7. 2007	11. 2005	6. 2006	20m
CN2	F	32-42	S	Ad N Prac	3yr	10.2007	11. 2005	7. 2006	24m
MW1	F	43-53	P	MidW	4.5yr	11. 2007	11. 2005	11. 2005	24m
NSP 2 SH	F	43-53	S&P	Sex H	1yr	12. 2007	11. 2005	5. 2006	24m
CM1	F	43-53	P	Com Mat	1.9yr	6. 2007	8. 2006	9. 2006	10m
HV1	F	32-42	P	Health Visitor	8yr	6. 2007	8. 2006	8. 2006	10m
MW2	F	43-53	P	MidW	13yr	6. 2007	8. 2006	10. 2006	10m
NSP 3 TV	M	32-42	P&S	Tiss Viab	4yr	6. 2007	8. 2006	8. 2006	10m
PN4/ CM2	F	43-53	P	Com Mat	4m	11. 2007	8. 2006	8. 2006	15m
NSP 4 EP	F	43-53	S	Epil Spec	6yr	12. 2007	8. 2006	10. 2006	14m
PN5	F	54+	P	N Prac	14.4y	10. 2007	8. 2006	3. 2007	14m
CM3	F	43-53	P	Com Mat	2yr	10. 2007	8. 2006	1. 2007	14m

PN6	F	43-53	P	Sen P N	19yr	6. 2007	11. 2006	Not Presc	7m
DN1	F	43-53	P	District N	4yr	7. 2007	11. 2006	11. 2006	7m
NSP Con	F	32-42	P&S	Cont Spec	5.5yr	7. 2007	11. 2006	11. 2006	7m
PN7	F	43-53	P	Prac N	20yr	9. 2007	11. 2006	11. 2006	11m
MH2	F	43-53	S&P	Mental H	1m	12. 2007	11. 2006	Not Presc	13m
CM4	F	24-31	P	Com Mat	18m	11. 2007	11. 2006	11. 2006	12m
WIC 1	F	43-53	P	Adv N P	3m	10. 2007	11. 2006	11. 2006	11m
WIC 2	F	43-53	P	N advis	4.5yr	10. 2007	11. 2006	5. 2007	7m

Appendix 8.

Group	
Gender	
Time & Date of interview	
Tape number	
Consent	
Location of interview	
Age Group	24-31 32-42 43-53 54+
Title / Role	
Time in current post	
Qualified to prescribe from-	
Began to prescribe	
Standards, guidelines, policies.	

Case Summary 1: Appendix 9.

Community Matron CM3: Prescribing: Elderly patients in primary care	
Employer	Primary Care Trust A.
Role	Community Matron
Time qualified as a prescriber	14 months Student intake 3.
Interview location	Open plan office on the upper floor of a GP practice. The office is shared with DN teams and HV's. Each nurse has a desk, the desks are grouped together in team areas. The room was continually busy, people coming and going, phones and fax machines continually ringing. Each professional group has their own area, seemed not to converse with each other. There were 'invisible barriers' between the sections. It felt a little uncomfortable, an us and them situation.
Policies and guidelines	Local guidelines based on NSF, NICE, BTS ,BHS guidance.
Transcription Summary	She had her confidence knocked early on by a rather unusual experience but didn't panic, thought about the situation referring to her prescribing knowledge and worked it through, is prescribing confidently and frequently. Talks about having to prove yourself to have a success to get respect from the doctors, new doctor don't know her and she feels perhaps don't trust her. Is conscious about changing things the doctors have started and gave examples using the doctor nurse game of how she sometimes will communicate with medical colleagues . Her feelings are not helped when she sees instances of poor medical prescribing where patients have lots of repeat prescribing gives example patient on multiple pain relief overdosing without realising it, this doesn't help her trust in them either. Has not felt supported by DN team who have not accessed her skills so she is trying to establish herself in a difficult area. Has used prescribing to look at the care of difficult patients and to work with doctors to find a way of managing them which prevents call outs is cost effective and keeps patient and practitioners happy. These ways are not conventional and probably don't fit gold standard practice but patients are advantaged by this and patient, nurse, doctor relationships are established though a team approach to caring for complex patients.
Other Comments	Quite a jolly person but there is a determination to get things done and to use prescribing in the role. There was a clear determination to define boundaries of practice with doctors and other nurses.

Case Summary 2: Appendix 9.

Childrens Nurse CN1 Prescribing: Children on hospital wards and in nurse led outpatient clinic	
Employer	Hospital Trust G.
Role	Specialist nurse. Childrens continence.
Time qualified as a prescriber	20 months – Student intake January 2005
Interview location	Office next to ward. Bleep insitu, bleeped and had to pop out once during interview. First interview had been cancelled on the day due to work pressures. One childrens ward had been closed due to funding and staff shortages. Children had been moved to other wards and there was some general confusion on the clinical environment.. Office location for paperwork and storing information
Policies and guidelines	Hospital guidelines urology. Disease specific protocols for prescribing
Transcription Summary	<p>No concerns of competence identified. Clear vision of where prescribing sits in role and the benefits it can offer patients and professionals. Professionally she felt competent to prescribe once qualified and felt uncomfortable asking doctor to prescribe on her behalf whilst waiting for organisation restrictions to prescribing to be agreed. Sees greater role involving patients in decision making particularly where prescribing is concerned and whilst will involve parents feels very much that giving choice raises many issues.</p> <p>Very frustrated about the need to develop a protocol for each drug and the lengthy process these protocols must go through she is authorised to prescribe that one drug. Has had to develop these protocols in her own time. Some resentment that at a sister hospital protocols were not required. Works on wards and has own nurse led clinics. Since prescribing the organisation are able to charge for first referral to her nurse led clinics so a positive benefit to the organisation is noted.</p>
Other Comments	A very confident and competent practitioner who is very clear of her role and her responsibilities.

Case Summary 3: Appendix 9.

Nurse Specialist epilepsy NSP6 Prescribing: adults and young people on hospital wards and in nurse led outpatient clinics	
Employer	Hospital Trust G.
Role	Epilepsy Specialist Nurse
Time qualified as a prescriber	14 months Student intake September 2004
Interview location	My office at the university (within hospital building) at practitioners request. Seemed in a hurry throughout the interview.
Policies and guidelines	Local policies based on national guidelines
Transcription Summary	Very organised pragmatic person, had made sure that prescribing was enabled before able to prescribe in view of delays to another nurse prescriber. Keen and got on prescribing and working within the restricted formulary agreed and authorised by the directorate. Specific area of prescribing responsibility working in a narrow and defined area of practice with limited number of drugs. Feels established in her role, comfortable prescribing and comfortable with her position in the team. She was disappointed that she was not to be allowed to prescribe a new drug which the hospital have categorised as consultant prescription only. Confident prescriber takes on board advice monitoring and accessibility of prescribing, talks about the importance of autonomy in prescribing. Takes firmly on board accountability, believes takes care to make the decisions and only does what the doctor would have otherwise done , therefore accepts accountability, feels knows the interactions of the drugs better than the doctors do.
Other Comments	Very confident, practical approach to prescribing. There was a sort of 'I can't see what all the fuss is about' attitude during the interview.

Case Summary 4: Appendix 9.

<p>Childrens Nurse CN2 Prescribing: neonatal infants on hospital ward and when being transferred from once specialist unit to another.</p>	
Employer	Hospital Trust G.
Role	Advanced Neonatal Nurse Practitioner
Time qualified to prescriber	24 months Student intake January 2005
Interview location	Office off the ward, busy neonatal ward environment, parents present, several doctors. Office was quiet area where advanced practitioners have facilities to undertake paperwork and study. A calm, quiet and well equipped area.
Policies and guidelines	Local neonatal practice guidelines
Transcription Summary	<p>Was really keen and motivated to prescribe despite delays, initially due to maternity leave almost immediately upon qualification and then employer restrictions. Works with other nurse prescribers, together they were able to plan the implementation of prescribing in the ward environment. She did take the lead in this. As soon as the employer restrictions changed (had previously required a protocol signed off for every drug, now have an accepted list of drugs) began to prescribe, is clear about the accountability and is careful to work within it. Ensures the doctors are also taking their accountability seriously. Was very clear about how prescribing enhances the neonatal nurse role. Found it difficult to work initially through the childrens' BNF but has become familiar with it. Is using pharmacology knowledge in clinical practice and likes using this ability to understand. Is unsure about working outside protocols, perhaps understandably in this area of care.</p>
	<p>Quiet but assertive and confident in her approach to prescribing. Took the lead but worked with others to enable the integration of prescribing on the ward.</p>

Case Summary 5: Appendix 9.

<p>Nurse Specialist heart failure NSP1 Prescribing: full prescribing as palliative care nurse for community patients. Limited prescribing as a community matron for elderly patients in primary care. No prescribing in heart failure specialist role.</p>	
Employer	Primary Care Trust A.
Role	Community Heart Failure Specialist Nurse
Time qualified as a prescriber	20 months Student intake January 2005
Interview location	Health Centre office. The nurse had booked the room through the health centre manager and I was informed that there was a time limit of an hour on the booking.
Policies and guidelines	Employer guidelines based on NICE guidelines.
Transcription Summary	<p>Is not prescribing, believes it would be unsafe as does not have knowledge about specialist role, been in role 14 months. Has had 2 other roles one during course, prescribed for some patients upon qualification. Second job prescribed some items for some patients. Has not prescribed in new community matron role. Expressed concern with regard to the accountability of prescribing. Appears isolated and vulnerable. No prescribing peers. Is currently working with a colleague to develop protocols to titrate doses. I am not sure that she has been able to accept the legal framework and accountability of independent and supplementary prescribing. Has very low confidence about prescribing ability but sees self as complementing Dr role. Is not able to clearly define the boundaries of her role and she seems to be trying to work out what is expected of her. Has seen a less complicated role in secondary care she would like to get involved with because patients are young, more stable and less complex. Record keeping is also an issue which needs to be resolved before prescribing can be accommodated.</p>
Other Comments	<p>She had a small desk and a filing cabinet in a room at the health centre. The room was occupied by other nurses and midwives on my arrival. There was little evidence of interaction between the applicant and other nurses in the room during my visit.</p>

Case Summary 6: Appendix 9.

Community Matron CM4 Prescribing: Elderly patients in primary care	
Employer	Primary Care Trust A
Role	Community Matron
Time qualified as a prescriber	12 months Student intake January 2006
Interview location	Matrons office Shares an office with another community matron
Policies and guidelines	Local guidelines based on national guidance, NICE, NSF,BTS BHS etc.
Transcription Summary	<p>Sees prescribing as a 'godsend', began with very simple areas of prescribing dry skin and moved onto other areas she felt comfortable prescribing in. Conscious of accountability and has done a lot of work on medicine reviews and checking for interactions. Relationships are important to her. Describes good rapport and relationship with the doctors works with, is learning from them and is conscious to give them the respect she feels they deserve and wants to avoid treading on toes. Talks very fondly of her patients giving many examples of how patients have been able to benefit from her prescribing role. She had thought about how nurse prescribing might feel for patients and seemed to use this awareness in her work. Very enthusiastic and committed to role and the patients. Is using role to try to keep patients out of hospital gives example of a patient who tries to manipulate her into prescribing additional products for indications that were not assessed and were inappropriate. She drew on her relationships with doctors and nurses and managed the situation without conflict, keeping things light-hearted but the point was made and the practice stopped</p> <p>Prescribing has been helpful in her role and her knowledge continues to develop.</p>
	Very friendly personality, appears to work well in teams and values the contribution of everyone. Gives time to build relationships and has a respectful approach to the contribution of others.

Case Summary 7: Appendix 9.

Mental Health Nurse MH1 Prescribing: in a nurse led non medical prescribing clinic, patients referred by psychiatrist.	
Employer	Mental Health Trust F.
Role	Community Psychiatric Nurse
Time qualified as a prescriber	25 months Sept 05 intake of prescribing students
Interview location	Quiet room Health clinic open access, mental health patients dropping into reception area, sitting about and talking to others in the room, secure access to back of the building.
Policies and guidelines	Employer guidelines based on national guidelines from NICE and Royal College of Psychiatrists.
Transcription Summary	<p>An innovative and enthusiastic nurse with vision and determination to use the prescribing qualification. Willing to lead others not willing to sit back and wait when opportunities are not been used to patient advantage. Wanted to use prescribing and sought a role for using it during the course, challenged the established order within nursing and the psychiatric profession. Worked with doctors to enable a new service to be set up. Not accepted by peers in fact many of them have ostracised him. He has got on with it and others seem to resent his efficiency and ability . Has seen patients benefit and has changed attitudes. Does enjoy changed role and respect of the psychiatrists and seems to wants to get those who are lagging behind the be caught out or shown the error of their ways through research.</p> <p>Saw the course as a valuable opportunity to learn from each other and had a core group of people around him during the course and he calls on them when needed now.</p> <p>Has taken each barrier or reason not to undertake prescribing and has found a way to remove it, has set up CPD which the Trust has now taken up.</p>
Other Comments	Friendly and supportive atmosphere on the building. I was introduced to other mental health nurses and doctors whilst in the building. They were all welcoming and expressed an interest in the opportunities presented by nurse prescribing

Case Summary 8: Appendix 9.

Practice Nurse PN2. Prescribing: By proxy only, uses prescribing knowledge.	
Employer	Primary Care Trust F
Role	Practice Nurse
Time qualified as a prescriber	24 months Student intake September 2004.
Interview location	Treatment room at GP surgery Well equipped room, dispensing practice in a very rural location. Has significant tourist activity and is likely to be treating visitors to the area. Working part time 2 days a week,
Policies and guidelines	Practice guidelines based on national guidelines, BHS, BTS ,NICE etc.
Transcription Summary	Reason for coming on the course was intellectual, as if never intended to prescribe but wanted to know about medicines. Gives the impression in the answers that she does prescribe but then says that she doesn't. Sees patients in terms of QOF but doesn't have time to develop CMPs would use independent prescribing but doesn't. Manages chronic disease using guidelines asthma, diabetes hypertension, expresses concern that would be floundering if guidelines were available yet does talk about looking at individual patients. Advises the other nurse prescriber who is prescribing. It is a dispensing practice which does cause problems. Says she hasn't really taken the step to prescribing on their prescriptions and them signing and signing her own. Dr checks, still prescribing by proxy. Part time is an issue, does not want to use handwritten prescriptions. There appears some concern not to affect working relationship with Drs and tries to accommodate their preferences doesn't want to get self into a situation where has to defend self or be in conflict with doctors.
Other Comments	Non confrontational character. Relaxed and appeared comfortable talking, talked openly. Appears confident in her knowledge and it would be reasonable to expect that she would be prescribing. Receptionists book appointments. Has in the room lists of what each GP prefers for prescribing which she refers to. Mentions her own previous studies before interview begins, she enjoys study and is very interested in research. At the end of the interview mentions her husband is a doctor who works in practice (where not disclosed) but also works with the BMA, she says he has been very interested in nurse prescribing.

Case Summary 9: Appendix 9.

Nurse Specialist sexual health NSP2 Prescribing: In primary and secondary care nurse led clinics	
Employer	Hospital Trust G.
Role	Community Sexual health Nurse Practitioner
Time qualified as a prescriber	24 months Student intake January 2005.
Interview location	Office at hospital treatment centre. Separate entrance to the centre with signposts indicating the nature of treatment at the centre. Interesting entering this centre, did feel conspicuous wondered if anyone might think I needed treatment. Can understand why patients might prefer to be seen at the health centre. Organised and calm atmosphere.
Policies and guidelines	Trust guidelines; Genital Urinary Medicine.
Transcription Summary	<p>It came across that for this prescriber it was very important to always prescribe within employer agreements and guidelines. She took time, once qualified and before prescribing for the first time to ensure the employer agreed to her prescribing. She read the prescribing policy and ensured she understood its requirements before prescribing. Frowns on a nurse who choose to prescribe outside the employers prescribing policy and finds injustice in the fact that the nurse she talked about was not caught out.</p> <p>Prescribing helped when job was at risk. Trust of doctors whom she prescribes with is very important to her, cites a mistake and puts great weight on the support received at that point, has a lot of trust in doctors an colleagues and believes it to be reciprocal. Values reciprocity in these relationships. Found the education a challenge but believes it was better than a degree in terms of improving her clinical practice which seems to be very important to her. She needs to justify time out and what she is doing in terms of her role rather than just personal development. Uses guidelines a lot and believes need to seek advice if patient presents outside the guidelines.</p>
Other Comments	Quiet and cautious approach to prescribing. Careful to stay within policies and guidelines but confident in her own prescribing knowledge and abilities.

Case Summary 10: Appendix 9.

Mental Health Nurse MH2 Prescribing: Team leader outreach care not prescribing	
Employer	Mental Health Trust F
Role	Team leader Community psychiatric nurse intermediate care team for older people with mental health problems.
Time qualified as a prescriber	13 months Student intake January 2006
Interview location	Empty day room at community hospital base. We met in the nurses office which was busy with practitioners taking and receiving calls. Busy hospital with older person and mental health focus. Supplementary prescribing policy in place soon to be reviewed
Policies and guidelines	Not prescribing but works to employer guidelines based on NICE.
Transcription Summary	Tentatively began to set up prescribing but was knocked back by the attitude of pharmacist and has difficulty using supplementary prescribing in a worthwhile way in her role. Policy does not support independent and so has not prescribed. Others in a similar position have commenced independent prescribing but she was not willing to go down this route. Was keen to show how her prescribing knowledge is being used. Is a team leader but not confident in challenging boundaries and pushing change. Is willing to lead practice but not the implementation of nurse prescribing in mental health practice. Is looking for a senior, a manager or lead to help her implement prescribing someone to help solve the problem she talked about with the pharmacist and someone to contact with practice queries. Is talking to peers who are prescribing but is still frightened by the role, seeing some of the challenges they have faced an resolved has not inspired her instead established the fear of prescribing. Can see a role for it within this new post established only a month before the interview.
Other Comments	I am not at all confident that she will actually prescribe as things are at the moment. Would need considerable buddy support to encourage integration.

Summary of Case Data.

Case Studies Total	26
Female	24
Male	2
Age 24 – 31 years	1
32 – 42 years	6
43 – 53 years	18
54 and over	1
Secondary Care	3
Primary Care	19
Secondary care / Primary care outreach	2
Primary care / Secondary care outreach	2
Group 1 prescribe from : August 05	5
Group 2 Prescribe from : November 05	8
Group 3 Prescribe from : August 06	6
Group 4 Prescribe from : November 06	8
Months prescribing : Shortest	7 months
Longest	26 months
Participants by intake	
By intake : 1 number of participants	5
Can prescribe from	Aug 05
Prescribing	4
Not prescribing	1
Time prescribing	24 / 26 months
By intake : 2 number of participants	5
Can prescribe from	Nov 05
Prescribing	4
Not prescribing	1
Time prescribing	20 / 24 months
By intake : 3 number of participants	8
Can prescribe from	Aug 06
Prescribing	6
Not prescribing	2
Time prescribing	10 / 14 months
By intake : 4 number of participants	8
Can prescribe from	Nov 06
Prescribing	6
Not prescribing	1
Time prescribing	7/12 months
Cases by Trust –	
Hospital trust G	18 accepted 4
Primary Care Trust A	28 accepted 15
Primary Care Trust B	4 accepted 2
Primary Care Trust D	5 accepted 3
Mental Health Trust F	3 accepted 2

Appendix 11.

Allocation of participant codes from group identification code.

First Intake Code	Study Code	Role
PN35	PN1	Practice nurse
PN36	PN2	Practice nurse
PN23	PN3	Practice nurse
GN2IC	GN1	General nurse
MH12	MH1	Mental health nurse
NSP24HF	NSP1 HF	Nurse specialist – heart failure
CN3	CN1	Children’s nurse
CN4	CN2	Children’s nurse
MW6	MW1	Midwife
NSP26	NSP2 SH	Nurse specialist – sexual health
CM2	CM1	Community matron
HV2	HV1	Health visitor
MW4	MW2	Midwife
NSP16TV	NSP3 TV	Nurse specialist – tissue viability
PN19/CM	PN4/CM2	Practice nurse – community matron
NSP14EP	NSP4 EP	Nurse specialist – epilepsy
PN13	PN5	Practice nurse
CM5	CM3	Community matron
PN9	PN6	Practice nurse
DN1	DN1	District nurse
NSP8CON	NSP5 CON	Specialist nurse – continence
PN26	PN7	Practice nurse
MH4	MH2	Mental health nurse
CM6	CM4	Community matron
WIC2	WIC1	Walk in centre
WIC3	WIC2	Walk in centre