

How Non-Medical Prescribing may Impact on the Service Development of a Clozapine Clinic

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New Ways of Working: How Non Medical Prescribing May Impact on the Service Development of a Clozapine Clinic

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Abstract

The purpose of this article is to discuss the possible implications of applying non medical prescribing practices to a Clozapine clinic in the Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust (RDASH). To reflect on such issues the current working practices, and the way in which non medical prescribing may be used, will be considered, thus identifying the perceived need and evidence base for a non medical prescribing role to improve the quality of care for service users within the Clozapine clinic. The apparent expectations of non medical prescribing from clinic staff, colleagues and service users will be considered including the suggested benefits, barriers to effective working, fears, concerns and practical implications.

Key words: Clozapine Clinic, Non medical prescribing, Service development.

Introduction

Non Medical Prescribing (NMP) has developed greatly in the last 20 years; however mental health services have only more recently begun to adopt the role for mental health nurses (National Prescribing Centre 2005). This greater autonomy for such nurses, and change in traditional roles, will impact on service development and ways of working and so such changes to practice need to be clearly justified as beneficial to service users. It also needs to be recognised that, even though changes are introduced to improve services, there may be initial apprehension from service users as such changes to working practices occur. This apprehension, if not appropriately managed, could become a barrier to new practices and needs to be identified and considered to minimise any potential difficulties (Snowden 2008). The use of non medical prescribing within a Clozapine Clinic is one specific area in which such issues can be identified and discussed.

Current Service Provisions

Clozapine has been shown to improve service users' quality of life and save money for the health service by reducing the number of hospital admissions (Duggan et al 2003). The monitoring of patients on Clozapine is a necessity due to the risks of agranulocytosis (BNF 2009). In many healthcare trusts this is done through nurse led Clozapine clinics, with initially weekly, then fortnightly and eventually four weekly appointments for service users. Nursing staff take blood samples, monitor physical observations, side effects and mental state through the use of local integrated care pathways and protocols. Specialist nurses such as those in the Clozapine clinic are well placed to advise medical colleagues regarding prescribing issues and it is thought that such 'de facto' prescribing is common in such areas (National Prescribing Centre 2005).

Clinic staff within the Rotherham service request prescription alterations as directed by the Consultant Psychiatrist following an outpatient appointment. They may also request a medication to reduce a side effect of Clozapine but must ask permission from the Consultant Psychiatrist and then request a junior doctor to complete the prescription, or alternatively refer the service user to primary care. Such prescribing practices can be argued to be time consuming and inefficient, sometimes leading to a delay in the changes to treatment for the service user. A further difficulty in this prescribing scenario is that clinic staff and Consultants

are often unaware of other medications the service user receives from their General Practitioner, as communication between primary and secondary care can be fragmented (Lester 2006).

More recently the European Working Time Directives have limited junior doctors' working hours meaning that they are less available for such, arguably, inappropriate duties like the routine monitoring of Clozapine patients (Harrison 2007). Also, the way in which Consultant Psychiatrists work has been under review in recent years, and it is suggested that current working practices are not in line with the 'New Ways of Working in Mental Health' initiative (Department of Health 2005; Mehta et al 2007). Service users now expect more from their health service with more time with staff to 'participate in decision-making as equal partners' in regards to their treatment options (Harrison 2007: 471). With such demands on current practices it is not surprising that Clozapine clinics are identified as areas which could particularly benefit from non medical prescribing, utilising the special expertise of the nursing staff (National Prescribing Centre 2005). In fact Leppard (2008) identifies Clozapine clinics as 'an excellent example of a role for a supplementary prescriber in mental health' (p.164).

Non Medical Prescribing in Mental Health Services

General medical services have been developing their roles in community based services with the Cumberledge Report (1986) examining the role of district nurses and recommending limited prescribing for district and community nurses. As the roles of community nurses developed with the Crown Report (1989) and the introduction of the nurse prescribers formulary (NPF) providing some autonomy for community nurses, mental health services made their own strides to develop specialist community teams to address the needs of service users. This included a more holistic approach and the rise of Assertive Outreach Teams, crisis teams and early intervention teams towards the end of the century. The National Service Framework (1999) recommended that assertive outreach should be available for those at risk of losing contact with services and on enhanced Care Programme Approach by April 2002. It also stipulated that 'round the clock' care should be available in mental health services, thus prompting the development of the crisis team providing 24 hour care when community teams were not available. Such progress in mental health services has led to more autonomy for nursing staff, although with continued multi-disciplinary team working, nurses now were given more responsibility in terms of the assessment and management of service users within the community, and the next logical step would be for staff to become Non Medical Prescribers.

This view is reflected nationally; the shift towards more access to services within health care appears to be reflected in the recommendations of the Crown report (1999) which states that prescribing rights should be extended to other nursing groups within health services. Furthermore, the NHS Plan (2000) suggested the majority of nurses should have prescribing rights by 2004, in some form. Mental health services prepared to adopt non medical prescribing practices but with some caution, tending to focus on the potential of supplementary prescribing rather than independent prescribing in mental health settings (National Prescribing Centre 2005). Currently in RDASH non medical prescribers are supplementary, although there is some ongoing work with a pilot scheme of independent prescribing which may be developed in the future. Supplementary prescribing requires that: once a diagnosis is reached and with service user's agreement, individual evidence based clinical management plans will be drawn up and agreed by all parties. (National Prescribing Centre 2005: 17).

It is a voluntary partnership between independent prescriber (in this case the Psychiatrist), supplementary prescriber (in this case the specialist nurse trained as a non medical prescriber and to run Clozapine Clinic) and the service user. This agreement needs to be reviewed at least annually, and the nurse must always prescribe within their competence

(Nursing and Midwifery Council 2006), referring back to the independent prescriber if they feel continued treatment is not within their sphere of knowledge. A clinical management plan (CMP) must be used as a framework for supplementary prescribing, it is a legal requirement and ensures 'safe and effective supplementary prescribing' (Smith & Hemingway 2005: 127). It is also a requirement that there is shared access to service users' records and that prescribing documentation is kept up to date (Department of Health 2005). In preparation for non medical prescribing in the Clozapine clinic a database of prescribing has been set up with shared access. This way of working is in line with current developments in New Ways of Working (Department of Health 2005) which suggest that 'traditional outpatient work' such as medication reviews can be taken on by specialist nurses (Harrison 2007: 473).

Identifying the Need for Change in Clozapine Clinic

According to Mehta et al (2007), Consultant Psychiatrists have huge demands on their time, and could be better suited to dealing with emergencies and more complex cases, rather than 'routine appointments', instead delegating such cases to other professions. The more effective use of time was one indicator that Clozapine clinics could benefit from the use of supplementary prescribing.

'It [Nurse prescribing] will work where there is a need for it. The need should be generated by service users. Where those needs are already being met effectively, adding more to the system may actually make things less effective'. (Snowden 2008: 70).

The current service provision is arguably not meeting the needs of service users, medication reviews are often delayed until seen at outpatient clinics, and then additional time is needed to organise the prescription. There is also potential for error as prescribing decisions are passed down to the junior doctors through Clozapine clinic staff. The use of CMPs and non medical prescribing would put the clinic on 'a more accountable and professional footing' (Leppard 2008:162). Jones and Jones (2005) identify potential benefits of non medical prescribing as 'quicker access to healthcare and more informed patients about their treatments' (p.527). It is suggested that the use of non medical prescribing in Clozapine clinics would lead to better medicines management, identifying the appropriateness of prescriptions and reviewing them more efficiently.

There are additional issues which relate specifically to the Clozapine clinic. The management of side effects such as hyper salivation and constipation associated with Clozapine could be dealt with in a much timelier manner if addressed at their regular appointment rather than waiting to see their Consultant Psychiatrist or making an additional appointment with their GP. Some service users have displayed a reluctance to attend their GP surgery to address such side effects, this may be due to anxiety, poor organisation skills, or previous negative experiences of their GP (e.g. Mental Health Act assessments can be a traumatic experience for the service user, or they may have difficulties in explaining their needs). Care will need to be taken in regards to the budget for medication; however initiation onto medication to manage particular side effects may increase concordance as it can significantly impact on a service user's lifestyle; prescribing responsibility can later be handed back to primary care once proven an effective management strategy for that service user. Stott and Cassells (2008) discuss the incidence of metabolic syndrome and weight gain for service users on Clozapine and its impact on self confidence and feelings of self worth. Such impact on daily life could be observed and acted upon, where necessary in a Clozapine clinic:

'Patients may also begin to appreciate nurses discussing their ADR [Adverse Drug Reactions] and hopefully reducing the health burden and improving medication concordance.'(Jones & Jones 2005: 530).

It is suggested that timely assessment and intervention can reduce the negative effects of such side effects whether it be through utilising the therapeutic relationship to offer advice, referring service users to primary care for further assessment and treatment, or prescribing medication in the clinic within the supplementary prescribers' competence (Snowden 2008).

Communication could also be improved between primary and secondary care through the use of non medical prescribing. In the development of a CMP the current medications supplied by the General Practitioner would be listed, these were previously unknown to both the junior doctor prescribing and the pharmacy dispensing the outpatient medication. Service users are already routinely asked in Clozapine clinic if they have been prescribed any new medication by their General Practitioner since their last appointment. By using a CMP the non medical prescriber could ensure that the relevant information is passed on to both pharmacy and the independent prescriber. Enzyme inducing drugs such as Carbamazepine and Phenytoin can reduce plasma levels of Clozapine, and cytochrome P450 inhibitors, such as Erythromycin, Fluoxetine and Cimetidine can increase plasma levels leading to a possible increase in toxicity and side effects (Bell et al 1998). Such interactions could be avoided through clearer protocols and better communication; non medical prescribing can facilitate this by liaising with the service user and other relevant professionals to ensure more accurate and up-to-date records.

Expectations in Implementing Non Medical Prescribing in Clozapine Clinic

The expectations for the implementation of non medical prescribing are high yet realistic. It is known that there may be practical issues to overcome but it is thought that the overall benefits to service users far outweigh any perceived possible difficulties.

It is to be expected that with such a radical change to working practices there will be some impact on the time required to assess and document prescribing within the Clozapine clinic setting, this certainly was the finding from the implementation of non medical prescribing in the memory clinic in Doncaster (Smith & Hemingway 2005). It may be that more non medical prescribers are required to deal with such a large workload, although it is hoped that the gradual implementation (as completion of CMPs will take some time to organise) of non medical prescribing will mean that adaptations can be made to practice to accommodate this. It is hoped that Consultant Psychiatrists will feel able to delegate routine assessments of service users on Clozapine to the clinic staff as they routinely see them at least every four weeks and can refer patients back to the independent prescriber if concerned or feel management is outside of their competence. Harrison (2007) notes a need for psychiatrists to at least 'be engaged in debate in the interest of our patients and of our own morale and well-being' in regards to embracing the increased autonomy of nurses (p.474).

It is anticipated that the service will become more efficient at addressing the service users' needs, including faster access to medication, regular review of mental health and better management of side effects. Through the development of a therapeutic relationship and regular contact, the non medical prescriber would potentially be able to facilitate a better understanding of the medication and involve the service user in the decision making process, with opportunity to ask questions and discuss options (Luker et al 1998; DH, 2004). This in effect may improve concordance, as service users feel they have a greater choice with more collaboration (Brimblecombe 2005), and it is argued that faster and more efficient management of side effects may further aid concordance as service users often cite such effects as a reason for stopping taking medication. Leppard (2008) found that many service users assumed she was already in the role of prescriber for Clozapine clinic, and although there were some concerns regarding change that it did actually facilitate 'more in-depth discussions about their medications' (p.162).

A further perceived benefit of non medical prescribing in the Clozapine clinic would be to address the issue of cigarette smoking and Clozapine serum levels. Research suggests that smoking can have some effect on the absorption of Clozapine (Bell et al 1998). So if a patient successfully stops smoking there is a need to measure serum levels and adjust the dose of Clozapine as required, this currently can be delayed whilst awaiting instruction from Consultant Psychiatrists or interpretation of Clozapine serum levels. During which time there is a potential for service users to have reached toxic levels of Clozapine in their system since stopping smoking, and to have increased side effects such as sedation and hyper salivation. It is also hoped that better working relationships with General Practitioner practices in the area would mean that they are aware of such issues and liaise with the Clozapine clinic accordingly. With more knowledge of the service users' medication the non medical prescriber would hope to also decrease the number of other potential adverse drug reactions, by having improved communication between secondary and primary care.

Potential Problems

There may be barriers to the implementation of non medical prescribing in the Clozapine clinic, but it is hoped that an awareness of such issues will better equip the staff to deal with them as, or if, they arise.

Firstly, is the changing role of the Clozapine clinic nurse in terms of their relationship with both colleagues and service users. Snowden (2008) suggests that nurses express concerns:

'That is, this role will somehow disturb a balance inherent within the (non prescribing) therapeutic relationship between mental health nurses and their patients'. (Snowden 2008, p68).

The move from nurse to prescriber could be suggested to be a change in the balance of power, and non medical prescribers in Clozapine clinic will need to exercise caution that both service users and themselves are confident and comfortable with it. There are concerns from service users that non medical prescribers may divert nurses from focusing on core parts of their role if devoting time to prescribing (McCann & Clark 2008; Harrison 2003). However others see the 'greater specialisation of nursing work' in a more positive light and it is acknowledged that non medical prescribers 'can only guess as to the impact' it may have (Jones & Jones 2005; Snowden 2007). Non medical prescribers need to be aware of such issues and endeavour to maintain their core skills and therapeutic relationships within mental health nursing, whilst service users will need a reassurance that nurses will continue to be an approachable point of contact with mental health services, and foster the process of collaboration.

Service users will need to be fully informed of the changes and what it means to their care package in the mental health services. Some express worries regarding nurses' 'knowledge base and competence' (National Prescribing Centre 2005: 13). If the process of non medical prescribing is transparent, and service users are reassured by both the independent and supplementary prescriber when completing the CMP, it is argued that such concerns will be found to be unwarranted. However, it is suggested that ongoing education in pharmacology and organisational support is required to facilitate good practice and reassure service users (McCann & Clark 2008). In Rotherham there is such a psychopharmacology course run by colleagues for South Yorkshire non medical prescribers, attendance also contributes to the required continued professional study (National Prescribing Centre 2005), and there is also a non medical prescribers' forum and ongoing clinical supervision with the independent prescriber.

There may also be inter-professional issues linked to 'professional encroachment' and 'power struggles' (Jones & Jones 2005). Initial reservations from colleagues may arise from

a lack of knowledge about what supplementary prescribing involves and how it may impact on their workload. Although there will be some initial organisation to set up the non medical prescribing role in the Clozapine clinic it should eventually benefit all involved, it is hoped that such concerns can be addressed with the support of the overall medical supervisor in order to foster good working relationships with the other Consultants. A qualitative study has found that psychiatrists reported an improvement in practice from introducing non medical prescribing, which in turn made their lives easier (Jones et al 2005). There will need to be clear protocols, and agreement between the supplementary prescriber and independent prescriber, on when it is appropriate to refer the service user back to the independent prescriber or on to the General Practitioner if concerns are raised outside of the supplementary prescribers' sphere of competence. As identified by Jones and Jones (2005), non medical prescribers need to 'accept that psychiatrists are experts in diagnosis and treatment' and recognise when such cases become more complex requiring more input from their Consultant Psychiatrist (p.534).

At present, supplementary prescribing is suitable within the Clozapine Clinic as it fosters a team approach to the management of service users with treatment resistant schizophrenia with fast and efficient access to medicines. Mental health trusts have been slower than primary care trusts in the implementation of independent prescribing in mental health services (National Prescribing Centre 2005). However, piloting of independent prescribing in RDASH suggests that such practices may be developed in the future for other areas such as the Clozapine Clinic. Current legislation would mean that independent prescribing may actually restrict necessary practices within the Clozapine clinic, as supplementary prescribing allows for prescribing outside of the summary of product characteristics indications when agreed in the CMP (NPC 2005). Although such practice may be a rarity rather than the norm, it is suggested that until legislation is reformed on independent prescribing for nurses to allow similar powers to those of medics, it is not suitable for the Clozapine Clinic service users. It is also considered that during the initiation of non medical prescribing within Clozapine Clinics, supplementary prescribing allows for an appropriate level of supervision and multi-disciplinary team working in order to develop prescribing knowledge and skills further.

Conclusion

In conclusion, there are clearly identified benefits to implementing supplementary prescribing into the Clozapine clinic: the removal of de facto prescribing increasing the safety of Clozapine clinic prescriptions; more in depth assessment of medications and side effects on a more regular basis, hopefully leading to timely management of them or referral to the appropriate care provider; more efficient access to medication and information for service users; and a reduction of the need for Consultant psychiatrists to review patients who are routine.

However, caution should be exercised as the impact of supplementary prescribing within the clinic can only be estimated at this stage (Snowden 2007). It is anticipated that there may be issues such as the increased work load of the supplementary prescriber, which may lead to a need for more supplementary prescribers within the clinic; resistance or lack of understanding from colleagues, possibly leading to unrealistic expectations or a reluctance to delegate responsibility to the supplementary prescriber; and concerns from patients regarding the relationship between them and supplementary prescriber, as well as their perceived level of knowledge.

It is an interesting time in the development of the Clozapine clinic and, although implementation may be complicated initially, it is hoped that once such arrangements are in place a more efficient service will run, which will be better for service users and staff within

mental health services. If independent non medical prescribing is implemented within the trust, careful consideration will be required as to how it may impact on the ability of the non medical prescriber to offer appropriate medication under current legislation. If non medical prescribing is successful further scope could be suggested to consider the future development and involvement of clinic staff in other areas such as: weight management, physical health assessment (where service users do not access primary care), and in Lithium clinics.

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