

New Ways of Working Reveal Old Errors in Medicine Management

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Abstract

Background and Aims

New Ways of Working (NWW) encourages extension of traditional caring roles. This paper discusses the impact of one of those extended roles: mental health nurse prescribing, in order to assess to what extent it meets the principles of NWW.

Method

Primary data was presented to two conferences on mental health nurse prescribing in 2008. The primary data constituted a grounded theory of the impact of mental health nurse prescribing in NHS Greater Glasgow and Clyde. This paper reports on verification of this theory from practising mental health nurse prescribers in England and Scotland.

Results

Thirty two practising nurse prescribers completed a questionnaire on the credibility of the theory. This feedback showed that the theory is a coherent representation of how nurses develop competence in prescribing.

Analysis

The process nurses go through to become competent closely mirror the principles of NWW. This offers practical support for the principles inherent in NWW and raises specific issues for the wider workforce.

Discussion

A consequence of analysing how high level nurses operate is to consider what happens to those nurses who do not operate at this level. In this instance deficits in medicine management can be seen as a function of *old* ways of working. Recommendations are made regarding structured education in medicines management from pre to post registration mental health nursing to address these deficits.

Introduction

New Ways of Working (NWW) (Department of Health 2007) encourages extension and amalgamation of traditional caring roles. Its focus is on competence, and, therefore, the principle underpinning the drive is about ensuring the right person is in the right place at the right time to offer the right support to any individual in need. As a principle this is difficult to argue against, but in practice the different professions can be quite defensive and go to great lengths to define the boundaries of their roles. In order to work as planned all professions would need to buy into the agenda completely (Jones & Harborne 2009) yet for many the thought of extending or, worse, blurring boundaries has a long history of provoking professional anxiety and resistance (Ovretveit 1989). NWW summarises its ambitions for multidisciplinary teams in the following manner:

- clarity of leadership based not solely on profession but on ability and competence;
- a system of distribution of responsibility rather than delegation;
- a focus on the use of skills to match the needs of service users and carers;
- an attitude of individuals taking responsibility for clinical governance standards;
- the delivery of care through a team approach;
- attention to efficiency in the delivery of care, with the removal of waste and duplication; and
- effective and intelligent management of caseloads
(Department of Health 2007: 6)

This paper does not offer a critique of these aims, nor a history of resistance to change. Rather it examines the impact of mental health nurse prescribing to contrast how well it aligns with this agenda. In this way a practical demonstration of these principles can be seen in action.

Specifically, it discusses the outcome of studying the impact of mental health nurse prescribing on prescribers in UK. By studying this process it can be shown that the nurses who have applied this new way of working in practice become competent in a coherent manner consistent with the principles of NWW. This process subsequently illuminates deficits in the *old* way of working. In other words, it will be shown that this instance engaging with NWW demonstrably improves care and simultaneously exposes gaps in the previous system.

Background

The Medicines and Human Use (Prescribing) (Miscellaneous Amendments) Order of May 2006 effectively means that nurse prescribers and other non-medical prescribers can, like doctors, prescribe any drug, with the exception of some controlled drugs, for any condition, given they are trained appropriately and feel competent enough to do so (Department of Health 2006). Competence is therefore a major issue for nurse prescribers. The stated aims are to:

- Improve patient care without compromising patient safety;
- Make it easier for patients to get the medicines they need;
- Increase patient choice in accessing medicines;
- Make better use of the skills of health professionals;
- Contribute to the introduction of more flexible team working across the NHS
(Department of Health 2006: 4).

It can be seen that there is clarity between these aims and those of NWW. Their underpinning philosophies are strikingly similar in that their focus is on delivering better care contingent on coherent flexible working.

Mental health nurses have been able to prescribe since 2003, and although nurse prescribing has become one of the most rigorously evaluated healthcare initiatives in nursing history, according to Gray (2008), mental health nurse prescribing remains consistently controversial. This is evidenced by the inconsistent uptake of the role (Ross 2009) and the enduring ability of prescribing to polarise opinion on whether or not it is something that mental health nurses should be doing (Gournay and Gray 2001; Bradley et al 2008). Clarity of direction is further eroded by the ambivalence towards prescribing shown by the latest reviews on mental health nursing in UK (Department of Health 2006; Scottish Executive 2006). Evidence of how mental health nurses apply prescribing in practice is therefore essential. This can then be contrasted with the stated aims of non medical prescribing (Department of Health 2006: 4) and by extension New Ways of Working (Department of Health 2007: 6).

This paper reports on verification of findings from a study into the impact of mental health nurse prescribing in UK. Earlier quantitative and qualitative analysis of data from 365 practising prescribers (Snowden 2007, 2008) and semi structured interviews with 13 mental health nurse prescribers and other stakeholders had provided primary data. Concurrent analysis of the literature (Snowden and Martin, in press) had resulted in a constructivist grounded theory of how mental health nurses develop competence in prescribing (Snowden and Martin, under review, b). This theory, summarised below, was presented at two national mental health nurse prescribing conferences in the UK in October 2008. Feedback was then sought on the coherence of the findings with practising mental health nurse prescribers.

In brief, the theory found that mental health nurses become competent at prescribing by integrating newly learnt complex skills and advanced knowledge of medicines into existing roles. This process was found to be a composite of four major themes (Figure 1).

Figure 1. Becoming Competent in Mental Health Nurse Prescribing



The themes can be defined as follows:

'Concording in Action'. This name reflects the finding that all mental health nurse prescribers attempt to apply the complex principles of concordance in practice. Each path to concordance is unique but can only be approached in a practical sense through action. This theme therefore entails content that discusses successful examples of where mental health nurse prescribers have improved an individual service user's experience of medicines.

'Managing Ambiguity'. This theme was named to recognise that there are conflicting demands on mental health nurses and that successful prescribers manage this ambiguity. Organisational support is clearly key here, but this theme focuses on individual examples of managing ambiguity. For example it entails content where prescribers present evidence of having balanced the pros and cons of integrating prescribing into their practice and claim to

have resolved it successfully. This is an important individual process related to a change in role identity.

‘Delivering Better Medicines Management’. This theme entails evidence that claims a more general benefit to engaging with mental health nurse prescribing. It differs from ‘concording in action’ in that it discusses potentially measurable benefits not necessarily related to specific therapeutic relationships. For example, it includes evidence of generally improved speed of access to medicines and includes content claiming that multidisciplinary team discussions have improved around medicine management.

‘Understanding v UNDERSTANDING’ entails content whereby psychopharmacology and general medicines knowledge are expressed as being raised as a function of prescribing duties. It is named in this visual manner (comparing small understanding with large understanding) to illustrate not only the raising of understanding but also to incorporate the reflection that such raised understanding generated in this population of prescribers. That is, as a function of raised understanding, prescribers realised that they did not understand as much as they assumed they did about medicines before they became prescribers.

Examples of the origins of these themes from the literature and primary data are illustrated in Table 2. During the presentations detail of the thematic categories was illuminated using verbatim quotes from the primary data. The primary data presented here was obtained from practising mental health nurse prescribers interviewed earlier in the study. Feedback on the coherence of these themes was then sought via a brief questionnaire (Table 1). This paper reports on responses to the final question of that questionnaire. The purpose of this question was to ensure data saturation of the thematic categories (Charmaz 2006) by asking respondents to provide free text responses to the overall study question. In other words, if any new themes emerged at this stage the theory would need to be reviewed.

Method

Table 1 Verification questionnaire

Q1	Are you a mental health nurse prescriber?
Q2	Are you practising?
Q3	Age Gender M F Band/role
Q4	In your role as prescriber, have you stopped more medication than you have started?
Q5	Is there anything about the model which is particularly coherent with your experience of developing as a prescriber?
Q6	Is there anything about the model which is particularly incoherent with your experience of developing as a prescriber?
Q7	What has been the most significant impact of mental health nurse prescribing on you?

Although this paper focuses on the responses generated from the last question, the next section briefly describes the purpose and rationale behind the questionnaire as a whole.

Validity

In order to discuss the design of the questionnaire it is important to keep in mind its purpose (Rattray & Jones 2007). This may sound obvious, but Rattray and Jones warn that this primary goal can often get lost whilst chasing the holy grails of reliability and validity. Whilst Meadows (2005) states that the value of a questionnaire depends upon its reliability and validity he joins Rattray and Jones in calling for a logical, systematic and structured approach to questionnaire design that does not lose the original purpose of the questionnaire.

In this case the purpose of the questionnaire is to obtain demographic and attitudinal data on the impact of nurse prescribing on nursing practice. Construct validity was therefore not sought. Construct validity relates to how well the items in a questionnaire *represent* the underlying conceptual structure (Cox & Cox 2008). The main aim of this questionnaire was to obtain opinion from practising prescribers on how well the themes presented correlated with their practical experience. As such all that was sought here was content validity and face validity. These were checked through peer review (Meadows 2005) and earlier pilot (Snowden 2006).

Content

Question 1 was asked to establish whether the respondent was speaking from experience. Given that the focus of this study has become centred on prescribing in action it was important to know whether the feedback was based on actual experience or not. Question 2 sought further distinction, as it is well known many qualified nurse prescribers do not practise (Bradley 2008). Any practising mental health nurse prescribers' views would therefore be considered optimal for the purpose of verification. Question 3 sought to establish basic demographics such as seniority of the respondents so any findings could be contrasted more accurately with other studies.

Question 4 was a hypothesis developed from analysing interview responses earlier in the study. Simplistic answers to this question were not expected but it was important to establish whether the anxieties expressed by opponents of prescribing in mental health nursing were founded in practice. That is, it seemed the prescribers studied earlier were extremely cautious. The relationship between caution and risk is not straightforward (Gold 2007), but if this population tended towards stopping rather than starting medication then it could be claimed caution is their default position.

Questions 5 and 6 sought opinion on coherence between the theory and the prescribers' actual experience. The questions specifically sought positive and negative instances in order to polarise responses and not just garner support. That is, the author had a natural tendency in the presentations to be enthusiastic about the findings and wanted to counter any possible bias this enthusiasm may engender. In actively seeking and requesting negative impressions of the model the author intended to create a more balanced response. This method had worked well earlier in the study (Snowden 2008).

Question 7 was a 'catch all' question asked in order to give free rein to responses which may not necessarily be covered by the model but which remained focused on the research aim. 'What has been the most significant impact of mental health nurse prescribing to you?' is a direct expression of the main research question.

These latter three questions in particular were designed to gather constructive and pertinent feedback in the widest possible manner whilst remaining easy and interesting for

respondents. It had been noted that the good response rate achieved in phase 1 of this study may in part have been down to the brief nature of the questionnaire (Cox & Cox 2008). Conference attendees were given a 20 minute presentation on the findings of the study followed by 10 minutes to ask questions. They were then asked to complete the questionnaire.

Ethics

Permission to undertake the wider study was granted by the local Research Ethics Committee and the health board research and development department. For this part of the study it was explicitly stated that completion of the questionnaire indicated consent to participate. All data were anonymised. Each returned questionnaire was allocated a number and the responses were catalogued only by this number. Any data considered clearly identifiable was not published.

Results

Over 100 mental health nurses attended the two conference presentations and 60 questionnaires were returned in total. Of the 60 returns 42 were from mental health nurse prescribers, 31 of whom were currently practising. The following responses are from the 31 practising prescribers. This is because the purpose of the validation was to focus on the impact of prescribing in practice.

The average age of practising respondents was 44.1 years. Six were male and 25 female. The majority were band 6 and 7. One was band 8 and three did not divulge this information. Two of those who gave no answer to this question gave their role as nurse consultant. Nurse consultants are never less than a band 8. The other non-responder was a crisis team leader, rarely banded less than 7. There was only one band 5 and this response was clarified with 'under appeal'. The respondent had previously been a grade F charge nurse indicative of comparable seniority to colleagues in terms of clinical experience. F grades were typically junior charge nurses. This is a very senior clinical population.

With regard to role, the majority ($n=5$) declared themselves to be community psychiatric nurses (CPNs) or community mental health nurses (CMHNs). Three were nurse consultants and three described themselves as charge nurses. The rest who responded to this question ($n=11$) had a wide range of roles. Given that CPNs, charge nurses and nurse consultants can also have diverse roles it is fair to say that this is not a homogeneous population.

Responses to questions four to six are reported elsewhere (Snowden, in press). In brief, those responses reported agreement on the clarity of the thematic categories. For ease of reporting the responses to question seven were categorised according to theme. In this way it can be seen how well they fit with the thematic descriptions presented earlier. Responses are presented in Table 2 along with examples of the origins of these themes from interviews and literature.

Table 2: Response to: ‘What has been the most significant impact of mental health nurse prescribing on you?’ sorted by thematic category

Theme	Concording in action	Understanding v UNDERSTANDING	Managing Ambiguity	Delivering better medicine management
Example from interview	We all know that not everyone takes their medication, or they may not take it as prescribed. They may not take it continuously. They may have many reasons why they decide to comply or not comply. And even people who do comply don't necessarily get a good outcome from complying...Therefore I think that the mental health worker has to treat medicine taking as a psychosocial event not just a chemical or biological event. (Interview 10)	It's learning around medication that changes. The classic thing that [nurse prescribers] say is that they used to understand medication and now they REALLY understand. They didn't previously take on the responsibility. That seems to change the way they act. (Interview 4)	'I am concerned that some nurses are moving into a field they are not competent in and we are losing hands-on skills which still are required to be performed by skilled nurses. [However], my prescribing enables me to be more effective and give a greater quality of care. (Interview 11)	A woman I'm seeing at home is most definitely happy. I'm in and out and I can just give her her prescription. I can see nothing but benefits to be honest. It's all about managing your time. At the end of the day your role needs to be managed. You're a prescriber. I don't think it takes a great deal out of my time I can't see it affecting anything therapeutic. It's not a long job. (Interview 8)
Example from literature	Having an enhanced knowledge base enables us to help with questions or concerns patients might have about taking their medication and other concerns they may present with, that might impinge on their concordance (Leppard 2008: 165).	[Other researchers] doubted whether present [course] content would enable nurses to practice informed prescribing decisions. Importantly, they suggest that as the nurse prescriber becomes aware of this lack of knowledge on informed prescribing, they are then reluctant to practise upon qualification (Jones 2008: 115).	It has been argued that nurse prescribing is a step backward to the biological 'cure' aspect of nursing, away from the caring and nurturing side ... [Some] describe nurse prescribing as a challenge to provide a more 'holistic' delivery of care to the client, and [others] have argued that nurse prescribing is a logical extension of the nursing role (Hemingway 2004: 37)	Supplementary prescribing has enabled the course members to work in partnership with medical practitioners. This closer working relationship is less time consuming and improves efficacy. Nurses generally spend more time with patients than doctors do and have the skills to promote health education... (Allsop et al 2005: 57)

Theme	Concording in action	Understanding v UNDERSTANDING	Managing Ambiguity	Delivering better medicine management
<p>Response to Q7: ‘What has been the most significant impact of mental health nurse prescribing on you?’</p>	<p>Building on the therapeutic alliance, continuity of care. Able to review my patients and monitor e.g. titration, and give time/good quality information about the action/side effect of the medication. Have the time to do ‘informed consent’ in a meaningful way.</p>	<p>Increased knowledge of why patients are prescribed certain medications</p>	<p>Became more eclectic in my approach. Clearer feeling developed for the boundaries of my competence</p>	<p>Improving patient care Increasing service to clients, “one stop shop”, I’d be lost without prescribing now</p>
	<p>Using/involving clients in concordance</p>	<p>Having a much fuller understanding in relation to medications-prescribing/administering</p>	<p>Holistic approach: adjunct to therapeutic relationship</p>	<p>Sharing and developing knowledge within the team to ensure the most appropriate treatment plan is put in place.</p>
	<p>Taking people off medication, better quality of life for clients</p>	<p>Me: increased knowledge and confidence More likely to check my work for mistakes</p>	<p>Improved work experience. Facilitation of new ways of working. Feel that I have an additional ‘tool’ in my box. Prescribing skills run alongside my PSI and brief therapy skills etc and I believe that they all interact and enrich each other</p>	<p>Process: Greatly improved communication within the process: GP-Patient-me. Improved experience for patient-speedier service. Streamlined</p>
	<p>To be able to respond to the immediate needs of the client, especially if they have a clinical management plan in place</p>	<p>Developing my knowledge of pharmacology, pharmacokinetics etc Increased awareness of medicines management</p>	<p>It adds another method to your range of interventions that you can use to help people. It demonstrates (by the pioneers) a future expanding role for mental health nurses (although no one can be sure of the future of nurse prescribing in mental health...)</p>	<p>Being able to hand over prescription to client rather than them waiting a number of days</p>
	<p>Concordance</p>	<p>Increase in competence, confidence and knowledge</p>	<p>Additional tool to help people. Have done BSc PSI and believe prescribing fits well in this package.</p>	<p>Enabling development of nurse led unit</p>

Theme	Concording in Action Prescribing at point of contact.	Understanding v UNDERSTANDING More competent and effective practitioner	Managing Ambiguity	Delivering better Management Medicine
	Consistent. More discussion about medicines	Increased knowledge as well as becoming more responsible for my practice	There seems to be an assumption that nurses either do psychological and social stuff or adopt the medical model. A PSI approach should welcome prescribing as the additional intervention to enhance the rest and make the nurse a more rounded and complete practitioner.	Most noticeable difference is the way medical colleagues are more willing to listen and discuss meds and treatment plans that they were before
	The ability to prescribe, where appropriate, in a timely manner in conjunction with a robust assessment and delivering psychological interventions	More timely medication changes and associated benefits for clients. Change in service provision due to increased knowledge now introducing medication monitoring focusing on physical health monitoring.	Most significant to me is increased confidence I have in my own competence across all aspects of my practice – I feel proud that I passed the NMP course and have been able to use it, and the experience of fighting to expand my practice has increased confidence (and competence?) across all areas of my work.	Relationships improved post qualification with the majority of psychiatrist colleagues
	If I am able to review a client's meds it may contribute to their ability to become involved in the PSI work and ultimately contribute to their recovery			Improved access for service users
				Able to meet service user needs more speedily. Team relate to me as a prescriber. Junior doctors seek advice/opinions

Analysis

It can be seen that in the main these responses align with the thematic categories. Many of the quotations could have fitted into more than one theme, for example the response 'Increase in competence, confidence and knowledge' could have been a factor in '**delivering better medicines management**' or an aspect of '**managing ambiguity**'. However, given that a choice had to be made for illustrative purposes it was categorised under '**understanding v UNDERSTANDING**' to reflect the process of growth inherent in the statement. This comparative process was followed throughout analysis (Charmaz 2006).

The most comprehensive comments related to the **managing ambiguity** theme, which is understandable given the complexity of developing new ways of working (Department of Health 2007). The most articulate responses came from those nurses who saw prescribing as an adjunct to existing enhanced skills. For example, two respondents who were also recently qualified in psychosocial interventions were keen to clarify the benefits of combining these skills with prescribing for the benefit of clients. This synergistic theme was also raised by four other respondents, one of whom even suggested this role extension had clarified boundaries as opposed to creating ambiguity.

Delineating between themes was sometimes problematic as discussed, but this was to be expected within a theory that explicitly recognised the interconnected nature of these themes. What is more salient for the purpose of verifying the themes is that all but one of the statements related to one or more thematic category. That is, only one statement did not naturally fit somewhere in the theory. This was the following statement:

'Having CPD related to pharmacology. This has legitimised and encouraged rather than being viewed as a strange hobby!'

Although clearly related to the theme of managing ambiguity and role development, it was difficult to categorise this statement in that the ambiguity resolved here belonged to the organisation and not the individual. If this statement is taken at face value the respondent has clearly been interested in pharmacology for some time but has been viewed as eccentric as a consequence. The ambiguity regarding the importance of medicines has therefore not resided with the respondent. If this is true then it is also true that this particular organisation has taken steps to resolve it. In other words this statement is still about managing ambiguity and resolving it to the satisfaction of the respondent, but it recognises that ambiguity about the importance of medicine management has been systemic.

It is difficult to generalise from one statement so this would need further corroboration. However, it is reasonable to claim that this process of verification has achieved data saturation (Charmaz, 2006) as all responses were parsimonious. Before considering these findings in more depth it is important to consider limitations of the study.

Limitations of the Study

It is not clear that these responses are generalisable either within or beyond UK. Outside the UK regulations and criteria for becoming a prescriber differ widely so comparison cannot be clear. According to Jones (2009: 17) there were approximately 650 mental health nurse prescribers registered with NMC in 2009. Although there would have been fewer in 2008 when this study was undertaken and it is known many registered prescribers do not prescribe (Bradley 2008), 31 is not a large sample and therefore caution in generalising is reasonable. It is also a self selected sample which inherently biases findings. Only motivated people go to conferences and answer questionnaires and therefore there is the

further issue of whether this sample is representative. There is also the added problem of how much the presentations influenced respondents. Given that the presentations entailed detailed descriptions of the thematic categories it is unsurprising to find that respondents use a similar language to answer questions on their coherence (Politz 1953). However, data gathering is always a trade off between the ideal and the practical and these limitations aside this approach was considered the best way to get as many active prescribers as possible to comment on the coherence of the theory.

Discussion

Nurse prescribers become competent through an interactive process of owning and demonstrating competence within an existing therapeutic alliance. This research provides evidence of how senior mental health nurse prescribers come to understand how advanced medicine management can be integrated into nursing practice. It has been shown that mental health nurse prescribers apply advanced understanding to deliver better medicines management generally. They do this through managing any ambiguity they may have had about the role by delivering enhanced concordance within individual therapeutic relationships. These practising mental health nurse prescribers are competent nurse prescribers. This finding is consistent with other research findings exploring mental health nurse prescribing (Norman et al 2007; Hemingway & Ely 2009; Jones 2008, 2009).

Prescribing can be seen as the pinnacle of a continuum of competence in medicines management from novice to expert. It is difficult to achieve and there are many barriers to overcome (Ross 2009; Hemingway and Ely 2009). However, these pioneers point the way towards the skills required for all nurses. This is relevant to NWW in the following respect: New Ways of Working encourages the most appropriate clinician (not profession) to take responsibility for tasks coherent with their individual skills. This is easier said than done, but in regard to prescribing this challenge has been taken up by innovative teams. These teams have provided the support for the generation of competent mental health nurse prescribers. An unexpected finding was that, in turn, these competent nurses revealed an unexpected level of incompetence in their colleagues.

It would be expected that nurses' understanding of medicines improves as a consequence of training to become a prescriber. That is a major purpose of the training. However, throughout this research there has been surprise expressed by prescribers as to assumptions they made about their previous levels of understanding. That is, they had not recognised how little they understood previously until they reflected from this new vantage point. This is important as many studies assumed that learning to prescribe would merely rubber stamp the de facto prescribing which has permeated the profession for years (Ramcharan et al 2001). Instead, learning to prescribe has illuminated the hazard of de facto prescribing.

At present not all UK universities deliver dedicated medicines management training to undergraduate and post graduate mental health nurses (Turner et al 2008). This is difficult to understand given that 92% of UK mental health service users are prescribed psychotropic medicines (Healthcare Commission, 2007) and nurses need to understand medicines in order to administer them safely (Nursing and Midwifery Council, 2008a: 1, see box 1).

Box 1. Nursing and Midwifery Council: Standards for Medicine Management (Version 1, August 2008, italics added)

'The administration of medicines is an important aspect of the professional practice of persons whose names are on the Council's register. It is *not solely a mechanistic task to be performed in strict compliance with the written prescription of an independent/supplementary prescriber. It requires thought and the exercise of professional judgement...*'

Introduction to medicines takes place in undergraduate training, and Morrison-Griffiths et al (2002) found that 90% pre-registration nursing curricula integrate medicines management into the syllabus. Whilst this is clearly sensible an unintended consequence is that there may be no formal assessment of theoretical knowledge within this approach. Assessment of competence is managed by clinicians (Nursing & Midwifery Council 2008b) and there is existing evidence that clinicians' understanding may not be fit for purpose (Ndosi and Newell 2008; King 2004). This paper adds further evidence to this claim. Without change this cycle perpetuates itself.

One way of breaking the cycle is to analyse those nurses who have successfully integrated high level medicines management into their practice in order to understand the process they go through to become competent. This study has provided the analysis. Prescribing can be viewed as the highest level of competence in medicines management in UK nursing. It is an advanced role and not necessarily relevant to all qualified nurses. However, it is a clear expression of the principles of NWW. By analysing the process through which mental health nurse prescribers become competent, an evidence based framework can be generated for delivery of safe and appropriate medicines management for all mental health nurses. That is, by focusing on aspects of practice that are conceptually coherent to the prescriber it is hypothesised that these would provide consistent and meaningful threads throughout all levels of medicine management education.

It is acknowledged that this is speculation. A process underpinning one level of expertise may not necessarily be transferable to generate competence at different levels of expertise. Nevertheless it is a testable hypothesis and this paper therefore offers a theoretical framework to address more general medicine management education grounded in the experience of practising mental health nurse prescribers. This framework translates easily into learning outcomes that can guide appropriate learning according to academic and clinical need. For example, the learning outcomes in box 2 could generate relevant learning for undergraduate mental health nurses within a dedicated medicines management module. In achieving these outcomes psychopharmacology can be learned within the dynamic context of its increasing prevalence and relevance to individualised care. This is commensurate with NWW whose aims are:

- clarity of leadership based not solely on profession but on ability and competence;
- a system of distribution of responsibility rather than delegation;
- a focus on the use of skills to match the needs of service users and carers;
- an attitude of individuals taking responsibility for clinical governance standards;
- the delivery of care through a team approach;
- attention to efficiency in the delivery of care, with the removal of waste and duplication; and
- effective and intelligent management of caseloads.

(Department of Health 2007: 6)

In ensuring that all nurses are given the opportunity to become more competent in medicine management, it is concluded here that these aims become more widely achievable.

Cascading these principles down the workforce should have measurable benefits to service users.

Box 2. Learning Outcomes for Medicine Management Module at Final Year Undergraduate level. (Bold Text Indicates Relationship to Thematic Categories Discussed Above)

At the end of this medicines management module the student will be able to:

1. Critically evaluate the concept of concordance in medication management (**Concording in action**)
2. Analyse the potential conflict between modern nursing ideology and legal and ethical issues pertaining to medication management (**Managing ambiguity**)
3. In psychopharmacological terms demonstrate critical understanding of likely adverse events related to psychotropic medication (**understanding vs. UNDERSTANDING**)
4. Justify an individualised approach to medication management (**Delivering better medicines management**)

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