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NURSING TIMES

MAREA BRENNAN THORNS ON HOW THE NON-MEDICAL PRESCRIBING PROGRAMME ENABLES PROFESSIONAL DEVELOPMENT FOR AESTHETIC NURSE PRACTITIONERS

I have always been of the opinion that chemical denervation of the face carried out for cosmetic purposes should involve the prescribing clinician meeting and consulting the patient face to face. The Nursing and Midwifery Council (NMC) has now also taken this stance after issuing an advice sheet for nurses who inject botulinum toxin at the close of 2007. In it they stated that they do not consider it to be best practice to administer botulinum toxin that has been prescribed remotely by a medical practitioner or by an independent prescriber who has not assessed the patient, as this is contrary to the guidance issued within the NMC *Standards for Medicine Management* (2007).

I am often asked by my nursing and medical colleagues if a patient group directive (PGD) may be used for Botox® and Dysport®. Neither of these drugs is licensed for cosmetic use and therefore may not be used in a PGD. However Vistabel® is licensed for cosmetic use but only

for 20 units within the glabellar. A PGD could then be used in this instance, using Vistabel®, but only for 20 units and only in the glabellar mechanism. How then, can a prescriber write a treatment directive for the cosmetic administration of a botulinum toxin injection from a remote location, without first seeing how the patients in their care animate the muscles of their face? And what if the patient's glabellar requires more than the licensed 20 units? And what if the patient requests other areas to be treated outside of the glabellar?

THORNY QUESTIONS...

How many nurses realise that they are not allowed to keep a stock of medicines on their own initiative? Do peripatetic nurses who are travelling to their treatment location know that they should only carry the prescription medicines required for their named patients on that particular day? How many patients have been seen in the first instance by a medical or non-medical

prescriber? Are these patients the prescriber's patients or the nurse's patients?

As a recent graduate of Oxford Brookes University the journal of *Aesthetic Medicine* asked me to give them a lowdown on what's involved with the non-medical prescribing qualification.

In May 2006 new government policy extended prescribing responsibilities to some non-medical healthcare professions 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

Qualified Nurse Independent Prescribers (NIPs) are now able to prescribe any licensed medicine for any medical condition within their competence.

A NIP working within medical aesthetics can

legally prescribe and administer medicines such as Botox®/Vistabel® in cosmetic procedures on his/her own initiative, and authorise others to do so under their patient specific direction. Although, the cosmetic use of Botox® is outside the product's licensed indications, prescribers including NIPs may prescribe Botox® for so called 'off-label' use and must accept professional, clinical and legal responsibility for that prescribing, and should only prescribe 'off-label' where it is accepted clinical practice.

Unlike medical prescribers, such as doctors, NIPs cannot legally order and receive supplies of Botox®/Vistabel® (using a prescription only medicine order of stock form) as the legislation is based on the principle that a prescriber prescribes and that his/her prescription is then dispensed by a pharmacist. However, many NIPs continue to work alongside a medical prescriber who is able to acquire a stock of the drug or work within a clinic which is registered with the Health Care Commission and may keep a stock of prescription medicines.

Anyone thinking of becoming an NIP needs to have been a qualified nurse for a minimum of three years, with the last year having been spent in the field in which they wish to prescribe, in this case aesthetic practice. They must be able to demonstrate to the Higher Education Authority (HEA) or University that they can work at undergraduate level; increasingly they may be required to undertake a short course on consultation and history taking skills prior to being accepted. The applicant must also have ensured that they have the cooperation of a medical supervisor, who will work with them for 12 supervised educationally led practice days. Their medical supervisor may be invited to attend a workshop at the university, where they will learn what is expected of them and receive a medical supervisor's handbook.

Most courses on non-medical prescribing are open to a variety of disciplines, including pharmacists, radiographers, podiatrists etc., but some HEAs run nurse-only courses. The NMC has published a set of standards in relation to nurse independent prescribing and works closely with HEAs on the validation of the courses that they offer.

Once accepted, the candidate will need to commit to at least 20 hours of study per week for six months, with the cost of courses ranging from £800-£2,400, depending on the HEA. On my course there were two objective structured clinical examinations (o.s.c.e.'s), two self assessment essays totalling 4,500 words, and at the end of the course a portfolio of prescribing competencies, which had to be submitted, typically between 25,000-40,000 words long! Written examinations and maths assessments may also be required depending on the HEA.

The prescribing qualification enables me



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to complete a patient treatment episode from start to finish and be truly independent from my medical colleague.

Patients at MBNS have better access to aesthetic medicines; as there is no more waiting for the next doctor clinic. In fact a recent patient audit in our clinic, showed a significant increase in satisfaction in obtaining more convenient appointments.

Although the NMC state that you may only prescribe in your area of competency, I was able to broaden the scope of my practice by critically examining the medicines that would be relevant in my aesthetic practice. In conjunction with my medical supervisor I was able to submit prescribing evidence within my competencies portfolio on a variety of additional medicines, which may be required in my clinic sessions.

After having gained a nationally recognised qualification, there is no doubt that I am competent to work independently as a nurse practitioner in medical aesthetics. I have been

assessed and examined on consultation and decision-making skills and am qualified to make a clinical diagnosis. I am now writing as many as 80 prescriptions per month and I have just undergone my first prescribing audit, and all was well! I feel confident that my practice is independently scrutinised, which is great for patients!

Nurses using a remote prescribing service within medical aesthetics should think very carefully about their legal and professional position. In particular the use of botulinum toxin A, where muscles need to be seen in expression, by the prescriber in order to make a decision on dose and site.

It is my belief that independent nurse practitioners must strive to work in the most professional way and plainly stick to best nursing practice. The non-medical independent prescribing qualification, was drawn up to benefit patients, and is a great opportunity for nurses to extend and develop their skills. ■