A new *script* for nurses

The introduction of nurse prescribing has offered nurses a vital role in getting drug and alcohol patients onto the right medication to contemplate recovery. Senior nurse manager Robbie Corrie explains the difference it has made to the service at Windmill House.

Nurse prescribing is relatively new in mental health nursing and more so in substance misuse, but recent amendments to The Misuse of Drugs Regulations 2001, enable nurse prescribers to independently prescribe to treat acute alcohol withdrawals and supplementary prescribe controlled drugs in secondary care. These changes have the potential to empower nurses like myself, who are working in an acute tier 4 inpatient setting.

Supplementary prescribing is a massive development in the speciality of substance misuse. The National Treatment Agency for Substance Misuse has outlined the potential impact for prescribing in this field. They estimate that between 100 and 200 nurses in substance misuse will train, and by doing so will (after development of the clinical management plan) be able to initiate, titrate, continue and adjust doses of controlled drugs in secondary care.

As a senior nurse manager of an acute inpatient setting who has in practice been prescribing for doctors for some time, the introduction of supplementary prescribing will formalise this practice that has been evident for many years.

Situated within Surrey and Borders Partnership NHS Trust in Chertsey, The Windmill Community Drug and Alcohol Team provides a wide variety of treatment options to people who have drug and alcohol problems, either in a community setting or from within a 10 bedded inpatient unit, Windmill House.

Windmill House is a tier 4 service delivery and we frequently admit service users with serious medical or psychiatric complications in addition to their substance misuse problem. It is not uncommon for new admissions to arrive intoxicated, therefore delaying the commencement of medication.

Services and treatments that are provided in Windmill House include assessment, detoxification from drugs and alcohol, and stabilising medication. Patients can be transferred to other drugs including buprenorphine, be put on naltrexone, and have secondary complications treated. Day and home detoxification is offered, and there is a six-week therapy based programme. They can be transferred to tertiary care directly from Windmill House.

Because of frequent reviews, changes in practice (including prescribing) and a policy of listening to the needs of service users, more and more users are successfully completing treatment in Windmill House – particularly those who were opioid dependent. In my experience it is opioid withdrawals that users find most difficult to cope with and therefore put them at a higher risk of relapse.

This is supported by the National Treatment Agency which concludes from studies that successful completion of opiate detoxification is generally higher in inpatient settings than in outpatient settings. The introduction of nurse prescribing in Windmill House will potentially give service users faster and more effective access to medication, particularly out of hours.

Independent prescribers can prescribe from the Nurse Prescribers' Extended Formulary, and in doing so take responsibility for the clinical assessment, establishing a diagnosis, identifying the clinical management of the condition, and ensuring that the prescription is appropriate.

Having just completed the extended independent and supplementary prescribing module at Surrey University, I envisage that I will shortly be independently prescribing alcohol detoxification medication regimes to service users who have alcohol dependence syndrome. Currently our nurses are dependent on a doctor (usually a senior house officer), who joins us on a six-month rotation and with limited knowledge of the pharmacology of substance misuse. They prescribe after a short induction period, under the supervision of our consultant, and with the guidance of local policy that was devised jointly by our doctors and nurses.

To assist nurse prescribers, The National Prescribing Centre identifies seven principles of good prescribing. These are:

- Examine the holistic needs of a patient. Is a prescription necessary?
- Consider the appropriate strategy.
- Consider the choice of product.
- Negotiate a contract and achieve concordance with the patient.
- Review the patient on a regular basis.
- Ensure record keeping is both accurate and up to date.
- Reflect on your prescribing.

The drug of choice in managing alcohol withdrawals is a benzodiazepine. In Windmill House we use diazepam, in conjunction with acamprosate and vitamins. Local policy states that the starting dose of diazepam is estimated by taking into consideration the severity of withdrawal symptoms; any history of previous symptoms including seizures; the age, sex, height and weight of patient; and whether there is serious impairment of liver function.

Dependent on consumption and the above factors, a diazepam regime for a 40-year-old man consuming 80 units of alcohol could be 40 mg daily. Additional diazepam would be prescribed as required, should withdrawal symptoms persist.

The benefits of my independent prescribing for this condition are that as senior nurse manager, my availability to service users admitted to Windmill House is greater than any of the doctors working within our team. The prescription can be reviewed each morning, avoiding the delay until the doctor arrives on the ward.

This is a great advantage in the management of substance misuse, as service users often become anxious or irritable if they perceive that their needs are not being met. In some cases, particularly with users who are heroin dependent, they may self-discharge in order to return to illicit drug use. This is a key time in keeping service users in treatment and if a nurse prescriber is available to review their medication during this period, it may be sufficient to keep them in treatment at this point.

Supplementary prescribing is defined as a new form of prescribing that can be undertaken by non-medical professionals after a doctor has made a

diagnosis and developed a clinical management plan. The benefit of supplementary prescribing in Windmill House would allow the nurse to review (under the supervision of the doctor) methadone and buprenorphine reduction regimes in agreement with the service user. Commonly service users (in my experience) prefer to reduce 5 mg daily, and rarely 10 mg. This reduction can be reviewed each morning to best meet their needs – either by increasing, decreasing or stabilising within the prescribed regime.

The Department of Health describes a clinical management plan as the foundation of supplementary prescribing, and obligatory before prescribing can take place.

Information must include:

- Name of the patient.
- Illness or conditions which may be treated.
- Date the plan takes effect and review date by independent prescriber.
- Reference to the class or description of medicines to be administered.
- Any restrictions or limitations as to the strength or dose of medicine.
- Relevant warnings about known sensitivities.
- Circumstances when supplementary prescriber should refer to independent prescriber.

Medication that could be prescribed in opioid dependence include methadone, buprenorphine, lofexidine, and naltrexone.

Methadone is an opioid drug that is used to prevent withdrawal symptoms in service users with opiate dependence, including persistent intravenous heroin users. Regular use causes physical dependency and once users stop, they will experience withdrawal symptoms. It is a class A controlled drug under the Misuse of Drugs Act 1971. A schedule 2 drug, it is legal to possess only if prescribed by a doctor and administered in accordance with the doctor's instructions.

The Royal College of Psychiatrists identifies methadone as probably the most widely used agent for the treatment of opioid dependence in the UK. In my experience it is the most difficult drug for service users to withdraw from. Never have I witnessed any service user reduce and complete a methadone reduction regime without the need for additional substitute medication.

Buprenorphine is becoming an increasingly popular option for the treatment of opioid dependence. It has been described as equally effective as methadone if administered at equivalent doses. As it is a partial opioid, it demonstrates low level of withdrawal symptoms when stopped suddenly. Some service users prefer it, as they report a feeling of 'clear-headedness' in comparison to methadone.

Dependent on dosage also, service users may experience a sense of euphoria in comparison to other drugs. In our unit we do not commence buprenorphine until methadone has been reduced to 25 mg administered, and then a period of at least 24 hours has elapsed before administering the first dose of buprenorphine. Methadone has by now been reviewed and discontinued.

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Another dilemma is: buprenorphine versus lofexidine? The nurse prescriber can educate the service user as to the benefits of both drugs, how they are administered and for what period. Lofexidine appears to be the drug of choice by service users on prescribed methadone doses of less than 50 mg daily, and buprenorphine for those on doses greater than 50 mg.

On some occasions however and for a variety of reasons, some service users have had 'bad experiences' with either, and are clear as to which medication they require.

Recent changes in legislation relating to nurse prescribing in substance misuse give nurses the potential to enhance service delivery in this speciality. Medication is the key to keeping service users in treatment and if it can be prescribed, reviewed or increased at the earliest opportunity, then it may be a tool in assisting more and more dependent people to remain in treatment and secure abstinence.

Although nurses working in substance misuse are latecomers to prescribing, in comparison to general nurses, they now have the opportunity to administer legally, a practice that many have been advocating to doctors for years.

Surely we would be fools not to?

Robbie Corrie is a senior nurse manager in Windmill Community Drug and Alcohol Team within Surrey and Borders Partnership NHS Trust and has recently secured the Extended Nurse Prescribing qualification at Surrey University. This article is based on his fully referenced essay for this course.