Prescribing by mental health nurses in acute general hospitals

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"Non-Medical Prescribing; Mental Health Nurse Prescribing in Acute General Hospitals"

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ABSTRACT: This article will consider the role of mental health nurses (MHN) working in a mental health liaison team (MHLT) as non-medical prescribers (NMP) for inpatients in acute hospitals. The author has spent 10 years working as a mental health liaison nurse within acute hospitals qualifying as an NMP in 2014. This has enabled the author to look at the role of NMP within MHLTs and how such roles enhance care MHNs give to inpatients. MHLTs support and advise our colleagues caring for patients with mental health problems in the acute general hospital environment, ensuring appropriate diagnosis and subsequent treatment. Consideration will be given to recent innovative services such as Rapid Assessment Interface & Discharge (RAID) and how these services could be further strengthened by MHN NMPs, along with possible barriers and facilitators to the MHN NMP role in the acute hospital. The author believes NMP roles within MHLTs are essential to patients experiencing mental health problems in acute hospitals, facilitating quick access to assessment, diagnosis and prescribing where appropriate.

Key words; Mental Health, Non-Medical Prescriber, Acute Hospitals, Mental Health Liaison Teams, RAID, Emergency Department.

INTRODUCTION: The Health & Social Care Information Centre (2013) showed that from 1.6 million mental health service users, 570,000 (37.4%) had one admission to an acute general hospital inpatient bed in 2011/12, and 630,000 (41.2%) attended the emergency department in 2011/12. The report concluded people with mental health problems are twice as likely to use acute hospitals than the general population. The Joint Commissioning Panel for Mental Health (2012) stated up to 170,000 individuals attend the emergency department each year following self-harm and that 5% of all emergency department attendances are coded as mental illness. Downey et al (2010) concluded in their study that there are a substantial amount of patients attending the emergency department who have an undiagnosed mental health problem.

Cooper et al (2013) identified that up to 40% of people attending emergency departments leave prior to mental health assessment. However this percentage is not consistent with some emergency departments reporting better assessment figures than other departments. The National Institute of clinical Excellence (NICE) (2011) guidelines on self-harm lay out clear guidelines for such attendances to the acute hospital. Aitken et al (2014) argue that emergency departments, in particular, require robust MHLTs, the focus being on self-harm assessment.

Aitken et al (2014) suggest 25% of the total patients admitted to the acute hospital with physical ill health also have comorbid mental health illness, and argue that the mental health component in these admissions are not assessed or treated whilst an inpatient. The Royal College of Psychiatrists (2013) suggest that up to 80% of acute hospital bed days include physical ill health with comorbid mental health illness.

It is clear from all of the facts and figures people with mental health problems are more likely to access emergency and inpatient acute services than the general population. Combining these attendances with individuals who attend who do not have a diagnosed mental health illness there are clear unmet needs putting acute hospitals under increasing pressure. Plumridge (2012) points out patients who have mental health problems in the acute hospital remaining untreated will undoubtedly lead to higher costs, slow down discharges with the possibility of death rates increasing.

Rapid Assessment, Interface & Discharge: There is a clear emphasis on assessment and treatment within the acute hospital for those who have a mental illness. The RAID model began in December 2009 aiming to deliver mental health services to Birmingham City Hospital acute hospital 7 days per week, 24 hours per day; the aim being to assess individual's mental health. RAID works within the emergency department and inpatient acute wards (Tadros et al 2013). Tadros et al (2013) demonstrated that the main types of referrals to mental health services from acute hospitals for assessment of mental health and associated risks included;

- Self-Harm
- Depression
- Dementia
- Alcohol related problems
- Psychosis
- Anxiety
- Drug Misuse
- Eating disorders
- Dementia
- Mental and behavioural disorder secondary to alcohol/illicit drug use
- Schizophrenia

Referrals also include patients who may already be known to and supported by community mental health teams and the management of their prescribed medication or diagnosis and symptoms.

Foley (2013) identified that the RAID model has been instrumental in showing the cost benefits for a mental health service in the acute hospital, suggesting that for every £1 invested in MHLTs £4 is saved. Parsonage and Fosey (2011) concluded that the RAID model can save up to £9.5 million per year for the acute hospital, though savings would depend on different sizes of the acute hospitals and the MHLTs commissioned to deliver such a service. This need is not only about health, there is also a political driver, with a proposed spend of £30 million by 2020 to enable better access to mental health services for those in acute hospitals (Department of Health 2014).

MENTAL HEALTH LIAISON TEAMS: It is clear that the figures point to there being a need regards mental heath and acute hospitals. As a result the focus regards service development has been on MHLTs as already shown by the success of RAID. For many years teams within acute hospitals were varied in their commissioning, on the whole being staffed by MHNs, either based primarily in the emergency department, or attempting to provide a service to acute hospitals in hours, with no service provision out of hours from MHLTs (Foley 2013).

This approach to service provision required clearer guidelines; as a result The Joint Commissioning Panel for Mental Health (2012) suggested that MHLTs in an acute hospital with 650 beds should have the following staffing;

- Psychiatric consultant x1
- Band 8 MHN x1
- Band 7 MHN x3
- Clinical Psychology band 8 x1
- Team PA Band 4 x1.5

This team construction could very much be described as a gold standard, the reality may however prove to be different as commissioning looks to save money within the NHS. Mental Health services have been required to make savings similar to all areas of health care (The Kings Fund 2015). However substantial funding is now being allocated to the assessment and treatment of mental illness within the acute hospital. Acknowledging acute hospitals have unmet needs regards care and treatment of people with mental health problems and political acknowledgement of this pressure highlighted this as a major issue regards solving the on-going issue of available beds in hospitals. It remains to be seen whether this will be enough to provide the gold standard services across all acute care trusts (The Joint Commissioning Panel for Mental Health 2012).

MENTAL HEALTH NURSES AND NON-MEDICAL PRESCRIBING; It is clear from the evidence that there is a need within acute hospitals for more proactive input from MHLTs (Eales et al 2006). Evaluation of the RAID model

has shown there is cost savings and improved access to mental health services. MHNs play a central role to providing these services, the role also providing an opportunity for NMP MHNs to develop individually along with developing MHLTs. The Royal College of Nursing (2012) stated that there are now 54,000 nurse and midwife prescribers in the UK. Since The Department of Health (2006) gave the responsibility and accountability to extend prescribing MHN nurses have begun to prescribe steadily increasing in number;

Year	TOTAL NMP	MHN NMP	MHN % of all NMPs
2006	37683	487	1.3%
2012	73611	4722	6.4%
2015	68275	4434	6.5%

 (Snowden 2006)

The steady growth of NMPs has mainly been focused within the community and general nursing (Hemmingway & Ely 2009). Dobel-Ober (2009) identified that RMNs have been reluctant to take on the role of NMP compared with their general colleagues. Jones et al (2010) suggested there are numerous reasons for this including a lack of knowledge to prescribe though qualified as a NMP. Bradley et al (2008) identified a lack support from peers and Skingsley et al (2006) described MHN as not having in depth knowledge to prescribe competently, therefore leading to reluctance to prescribe, preferring to rely on more familiar medical prescribers. Jones et al ((2008) argues that the level of pharmacology training in preregistration MHN does not prepare the nurse for NMP status, and that without fundamental changes in preregistration NMP MHNs will continue to lack in depth knowledge of pharmacology and therefore be reluctant to prescribe.

Blanchflower et al (2013) suggested there are two factors which impact on prescribing; internal, such as the confidence to prescribe; and external, including peer pressure, legislation and disagreement with other health care professionals over what should be prescribed. It could also be argued that medical teams within acute hospitals prefer medical prescribers, having little confidence in non-medical prescribing; such beliefs make it a challenging situation for NMP MHNs to practice and develop NMP skills (Wilhelmsson & Foldevi 2003).

Dobel-Ober et al (2013) contend that although there is a growing trend for MHNs to undertake NMP training, many do not utilise NMP skills once they are qualified. Patel et al (2009) identifies a concern from psychiatrists regards RMN NMPs surrounding the pharmacological knowledge that RMN NMP possess and suggesting a lack of competence. There is also the possibility that this change in roles has swayed some of the balance in the relationship between psychiatrists and RMNs. However Power et al (2009) found that MHNs and psychiatrists were on the whole in favour of the NMP role, however Ross & Kettles (2012) concluded 60% of qualified RMN NMPs were not prescribing in practice and that there were numerous factors influencing this

including perceived damage to nurse patient relationship and lack of clinical supervision.

There is clear evidence based on research linking RMN NMPs with positive outcomes for service users and increasing the RMN knowledge base surrounding prescribing (Bradley & Nolan 2007). Building on the positive elements of RMN NMPS would need to include ongoing medical supervision, peer supervision and continued acquisition of prescribing knowledge. Such an approach would enable RMNs to break down barriers which appear to hinder the progress of NMPs within mental health nursing. Recognising there are barriers to NMP RMNs enables such issues to be challenged. Within acute hospitals such barriers may well remain, however this may also present an opportunity for development not only of MHN NMPs generically but also to individual NMP MHNs.

NMP RMNs IN THE ACUTE HOSPITAL: There has been a gradual increase in the numbers of RMN NMPs registered with the NMC, the focus of this being within community teams, outpatients and older adult services also based in the community (Hemmingway & Ely 2009). The challenge is how to take this role and make it work in a challenging environment such as the acute hospital inpatient and emergency departments. Goswell and Siefers (2009) discussed the evidence that most literature for NMP has been based within the community setting with little being aimed at the acute setting. However they concluded NMPs add value to patient care, collaborate effectively with the multidisciplinary team and ensure quick access to prescribing within acute units. Jones (2011) came to a similar conclusion regards NMPs within the acute wards in that there was no statistical difference between NMPs and medical prescribers regards consultation and prescribing. The conclusion being there was little difference in the prescribing of both groups. Stenner and Courtenay (2008) also concluded NMPs encourage collaborative working whilst prescribing within their own competencies.

Jones (2011) and Goswell, Siefers (2009) and Stenner and Courtenay (2008) based their findings on general nursing NMPs. Therefore there can be an inference that MHN NMPs working within acute environments add value to patient care and the multidisciplinary team. There are numerous articles and research based on MHLTs and their positive impact on the acute environment (Baldwin 2004, Wand & Fisher 2006, Tadros 2013).

The author's own experience suggests most acute staff are welcoming of the specific expertise that MHNs provide in both assessing and managing patients with mental health problems in the acute environment. In the acute hospital this follow-up is vital providing consistent contact with a patient suffering from mental health problems who may feel isolated, confused or suffering from an altered state of reality. Seeing a familiar face during the initial treatment will ensure support for the patient and the staff in their management of the patient, who are often unfamiliar with this type of acute management of mental illness.

RMNs in acute hospitals have primarily relied on acute medical teams to prescribe once advice has been given. MHLTs with psychiatrists available have had the benefit of, either asking the psychiatrist to prescribe, or seeking advice and reiterating that to the acute medical team. This suggests prescribing for mental health in the acute environment takes time where an NMP is not involved. Discussions between various health professionals take place. Relaying decisions to the acute medical team takes time. Awaiting the psychiatrist to review and prescribe, or waiting a discussion with the psychiatrist to get a clear plan on prescribing all takes time, leading to delays in treatment and possible exacerbation of symptoms. The RMN NMP has skills and knowledge to circumvent this elongated chain of communication, ensuring timely prescribing for patients and support of the medical and nursing teams in the acute environment. However this can only be achieved by the RMN NMP working within their own competency, it is vital that for any situations that fall outside this range of competency, further advice is sought (Bolam v Friern HMC 1957).

Discussions with acute medical teams promote timely access to prescribing via MHN NMPs, with the understanding they have pharmacological knowledge to make safe and accurate prescribing decisions. MHN NMPs have an opportunity to enhance care for patients with mental health problems in the acute hospital. There is clear evidence that with the correct support from colleagues within the MHLT and collaboration with other health care professionals MHN NMPS can develop their roles in the acute environment successfully (Wand & Fisher 2006). Wainwright and Canning (2008) identified NMP as a positive move away from traditional nursing boundaries providing the patient with consistency, less time waiting for prescribing, and more information given to the patient on prescribing, possible side-effects and how long to wait before any therapeutic effects occur.

CONCLUSION: RMN NMPs working within MHLTs can provide expert prescribing to acute hospitals that are clearly struggling to manage a large population of patients with known and unknown mental health problems. The challenge for RMN NMPs is to ensure they play a central role in MHLTs, challenging traditional prescribing roles through collaborative working. MHN NMPs have to ensure when qualified as NMPs they have sufficient pharmacological knowledge, using the skills of prescribing to enhance patient care. Such shortfalls in knowledge could be addressed by extra pharmacology education specifically targeted at MHNs during the NMP course about core medications they would be prescribing. Also increasing the level of pharmacology teaching during preregistration training for MHN students may help prepare MHNs for prescribing more effectively in the future.

RAID has shown that MHLTs provide consistent support and care with positive cost implications for acute hospitals. This galvanised the department of health to provide funding across the NHS to support those with mental health problems in acute environments, however whether the funding will be enough will require further evaluation. There are numerous articles that clearly show MHLTs have a positive effect on acute hospitals. Adding NMPs to

MHLTs will have the effect of increased access to prescribing in and out of hours.

However there is little research at present regards MHN NMPs in the acute environment. Though all other evidence from other disciplines concludes NMPs in the acute wards has a positive impact on patients and the multidisciplinary team, it remains to be seen whether there would be similar conclusions regards MHNs prescribing in acute hospitals. Therefore further research into this emerging area of prescribing is essential.

KEY POINTS

Acute hospitals have to treat a large number of patients with comorbid physical and mental health problems.
Mental Health Liaison Teams working within acute hospitals have been shown to be effective in supporting and treating those with mental health problems however there are differences in service provision throughout the NHS.
Non-Medical prescribing Mental Health Nurses working within the community provide positive patient care and collaborative working. However research has concluded that many qualified NMPs in mental health do not prescribe.
Prescribing for mental health in acute hospitals is a challenging environment. There is little evidence regards this specialism. Evidence from other NMP disciplines prescribing in the acute environment concludes that this is a progressive area of nursing, challenging traditional roles and enhancing patient care and collaborative working.

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