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Inter-professional Prescribing Masterclass for Medical Students and Non-medical Prescribing Students (nurses and pharmacists): A Pilot Study

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ABSTRACT

Background and Aims
Prescribing errors cause significant patient morbidity and mortality. Current legislation allows prescribing by different health professions. Inter-professional collaboration and learning may result in safer prescribing practice. This study aimed to develop, pilot and test the feasibility of a simulated inter-professional prescribing masterclasses for non-medical prescribing students, medical students and pharmacists.

Methods and Results
A three-scenario, simulated patient session was designed and implemented by an expert panel. Medical students, non-medical prescribing students and pharmacists worked together to formulate and implement evidence-based prescriptions. The Readiness for Inter-professional Learning Score (RIPLS) and a self-efficacy score was administered to the students and the Trust in Physician Score to the simulated patients. A focus group was convened after the intervention and the results thematically analysed. Overall, the RIPLS and self-efficacy scores increased. Pharmacists showed the highest rating in the
Trust in Physician score. Focus group analysis suggested that the intervention was viewed as a positive educational experience.

**Conclusion**

An inter-professional prescribing masterclass is feasible and acceptable to students. It increases self-efficacy, readiness for inter-professional learning and allows students to learn from, about and with each other. A larger trial is warranted and the use of feedback from simulated patients explored further.

**Keywords (3-5 words)**

Prescribing Safety
Team working
Simulation
MAIN TEXT

Introduction

Protecting patients through safe, effective prescribing is essential for sustaining health. In the UK, medication errors are the third most common cause of patient safety events (1, 2). Current prescribing legislation permits doctors, nurses, pharmacists, physiotherapists and podiatrists to independently prescribe any medication within their professional competence.

A recent in-depth investigation into the causes of prescribing errors by foundation year (FY) doctors (EQUIP study) reported the prescribing error incidence rate as 5.9% – 10.3% for doctors, with the highest rates seen in FY doctors, and 6.9% for nurses (3). One of the EQUIP study recommendations was inter-professional education in safe prescribing, which is reflected in the Scottish Government document, Prescription for Excellence (4).

Prescribing is a complex process which frequently involves collaboration with different health care professionals in order to make safe, effective, and evidence-based prescribing decisions. A problem solving, case-based approach to learning allows students to work collaboratively with other professions to
solve complex prescribing dilemmas, which aim to optimise clinical outcomes. The development of competence requires a combination of knowledge, performance, skills and attitudes, which is attained through inter-professional observation and supervision. This inter-professional experience is intended to help appreciate professional boundaries and identify when the skills of another profession may be required.

Simulation in clinical education has been shown to be beneficial for the development of clinical practice and skills, permitting the learner to develop skills in a controlled and safe environment (5-7). This has recently been demonstrated in a large scale study with nurse and doctor participants (8). However, as far as the authors are aware, there is no published evidence that this type of learning occurs between nurse and pharmacist non-medical prescribing students and medical students.

The aim was to develop, pilot and test the feasibility of a simulated inter-professional prescribing masterclass for medical students and nurse and pharmacist non-medical prescribing students.
Methods

An inter-professional, expert advisory panel was convened to design, pilot and evaluate an inter-professional masterclass with trainee prescribers from medicine, nursing and allied health professionals and pharmacy. The expert advisory panel comprised of four members; one doctor (AR), one nurse (RP) and two pharmacists (AC, MK) with expertise in prescribing, education and simulated teaching. Medical students learn to prescribe at an undergraduate level while non-medical prescribers and pharmacist prescribers are able to gain extra skills in prescribing post-registration.

Three cases, which would commonly be encountered in practice and at the level of a foundation doctor or non-medical prescriber, were designed; one sepsis, one polypharmacy and one community-based case.

Insert box 1.

Model answers using local and national guidelines were prepared. The sepsis and community scenario cases required a history to be taken from a simulated patient, a suitable diagnosis to be decided upon and a prescribing management
plan formed and executed. The third, a polypharmacy case, was designed as a paper-based scenario and focused on developing skills in medication review, recognition of adverse drug reactions and BNF/local formulary navigation. Each scenario lasted 45 minutes, was facilitated by a member of the panel and one participant from each of the three professions formed the delegate groups. On completion of each scenario, the facilitator checked the prescribing decisions made against the model answers and gave feedback on participant performance. Students and simulated patients were also encouraged to feedback on their perceptions of the scenario.

To verify accuracy, relevance and timing, the scenarios were initially tested with a cohort of non-medical prescribing students. Ethical approval was sought and approved by Edinburgh Napier University and the University of Edinburgh Medicine and Veterinary Medicine Student Advisory Committee. NHS research ethics approval was not necessary.

Recruitment

Participants were recruited through participating organisations. A poster with a point of contact was circulated to eligible participants. Simulated patients were invited via a university simulated patient programme. Prior to the masterclass
all participants and simulated patients were briefed on the purpose of the project, the anonymity of any results and compliance with data protection. Written consent was requested.

**Outcome measures**

Evaluation consisted of a validated pre- and post-readiness for inter-professional learning score (RIPLS) (9) and a self-efficacy score (10). Simulated patient views were evaluated using the trust in physician score (11). Following the masterclass a group discussion was convened with all participants and facilitators to provide a more in-depth, descriptive exploration of the intervention.

*Readiness for inter-professional learning (RIPLS).*

The RIPLS questionnaire consists of 12 questions using a 5 point Likert scale with end points ‘strongly disagree’ to ‘strongly agree’. An overall RIPLS score (range 12-60) is calculated and a higher score correlates with greater readiness for learning. A free text comments box is available for any additional relevant comments relating to the benefit of the education session to the participant and patients.

*Self-efficacy score*
Self-efficacy perceptions are linked to the likelihood of taking on a certain task and they influence not only the ability to perform a task but also goals and aspirations (12). The self-efficacy score is a 16 item score validated for students in medicine, dentistry and other health professions. The scale was used to calculate an overall self-efficacy score (range 16-160). An increased score pre and post masterclass indicates increase confidence and was considered a useful measurement of effect.

*Trust in Physician scale.*

The decision to involve service users in the evaluation was based on the principle that an effective and trusting patient/practitioner relationship is associated with improved adherence to treatment regimens (11, 13, 14). The term ‘physician’ was changed to ‘health care professional’ to more accurately reflect the participant group. The scale is an 11 item scale and the total score is calculated out of 100. The higher the score, the greater the trust in the health care professional.

*Descriptive data collection*

On completion of the masterclass a group discussion was carried out with all participants. This was led by a member of the expert panel using a topic guide.
based on the principles of best practice debriefing techniques (15). Free text comments were also collected from RIPLS and self-efficacy questionnaires.

**Data Analysis**

The RIPLS and self-efficacy scores were compared (paired t-test) pre and post masterclass using Microsoft Excel 2003 and Graph Pad QuickCalcs 2015. Although the sample was small, the significance of differences in scores was tested. The pilot served to provide an estimate of the difference in scores which can be used for future sample size calculations.

Qualitative comments from group discussion were analyzed using Clark’s theory of inter-professional learning as a framework (16). This theory of social learning suggests that participants are encouraged to view the world from a perspective different to their own. This develops professional judgement, breaks down biases and false assumptions thereby improving team working. Applying this framework, all free text comments and notes from the group discussion were read, themed and cross checked by the expert panel.
Results

The masterclass was attended by 10 participants, two fourth year medical students, three pharmacist independent prescribing students (IPs), three nurse prescribing students (NMPs) and two simulated patients. One medical student was unable to attend at short notice. All nurse and pharmacist prescribing students were post registration while the medical students were undergraduates.

Analysis of the discussions, prescriptions and documentation at each of the scenarios suggested that participants displayed safe, effective, evidence-based prescribing. The overall RIPLS scores pre-masterclass and post-masterclass significantly increased (two-tailed $p = 0.019$). Prior to the masterclass it was observed that the pharmacist IPs group placed the highest value on inter-professional learning where the NMPs group placed the lowest value. Following the masterclass the NMPs score increased significantly ($p = 0.035$) and had the same value as the IPs. The increase in medical students and IPs scores were not significant.

INSERT TABLES 1 AND 2
Self-Efficacy

Overall participants reported an increase in confidence in their abilities following masterclass participation. Self-efficacy scores increased after the masterclass (p = 0.010). Medical students were least confident prior to the masterclass and IPs were the most confident group. The increase in confidence confirms the comments received in the RIPLS questionnaires.

INSERT TABLES 3 AND 4

Simulated patient feedback.

Simulated patients scored the professionals after each case (table 5). Nurse prescribers scored the lowest and pharmacists scored the highest mean scores.

INSERT TABLE 5

Free text and group discussion results

The free text comments from the pre and post questionnaires and group discussions suggested that the masterclass was positively received.
‘Working in teams to make decisions regarding prescribing. Will help as a doctor in knowing how to seek help and what the competences of other staff members are’ (Medical student).

Participants felt it beneficial to work in small numbers. The simulated patients commented that it was interesting to watch different professions working and to see how they listened to each other. They also commented on how well the groups worked together stating ‘Would not know that they did not know each other’.

All participants developed an awareness of other professional roles. Medical students commented on their improved knowledge of the role of the pharmacist and nurse in the clinical team, nurses commented on their reliance on the pharmacist for accuracy of prescribing decisions and pharmacists noted the importance of considering a more holistic approach to the prescribing consultation. Participants noted that the learning would be beneficial in both pre and post graduate education.
Discussion

The results suggest that an inter-professional prescribing masterclass is worthwhile and feasible. The scenarios were appropriate although a broader range of scenarios may be required if participants were recruited from a wider range of clinical backgrounds. This would provide the opportunity to challenge the participants within and outside their current competence. Furthermore, by incorporating the patient safety agenda into cases by using critical incidents and examples of complex patient management the masterclasses would expose participants to more complex cases in a controlled simulated environment.

The success of the masterclass may be reflective of the cohort recruited and the clinical experience of the nursing and pharmacist independent prescribing students. Participants were a small number of self-selected students and practitioners. It is unknown how this would translate to a larger group of students or if this was a compulsory part of prescribing education however this study suggests that it is a positive learning experience. The RIPLS score was able to demonstrate a change in attitude towards inter-professional learning which is anticipated to benefit collaborative clinical practice.
An increase in self-efficacy scores is consistent with previous inter-professional research (8, 17). A significant increase in confidence was noted for the medical students. Medical students may have had low scores prior to the workshop because they have little or no exposure to the clinical environment whereas the other professional groups were postgraduates with an excess of 3 years clinical experience. There is some evidence that simulated education has a positive impact on patient outcomes and that self-efficacy has a role in improving prescribing skills which may improve patient safety (7, 8, 18), however further research in this area is recommended to demonstrate what effect postgraduate prescribing simulation has on self-efficacy and most importantly patient outcomes.

Involvement of the simulated patients in feedback is an important precedent for person-centered care. Although previous studies have noted that simulated patients have a role to play in the student’s learning journey there is limited evidence of use of a standardized measurement instrument to assist with feedback (19). The trust in physician score may be a useful instrument for future simulation research. Moreover, the positive feedback received from the simulated patients during the focus group suggested good team work and communication skills were important to the simulated patient. Shared decision
making between the patient and the health care professional is associated with improved medication adherence (20) and it is recommended that feedback from patients in a simulated environment should be further explored.

The free text and group discussion evaluation suggested that the participants learned from, about and with each other. This social process is considered to be as important as the content of the masterclass and is associated with patient safety (21). Participants had an improved understanding of the importance of team working in effective learning (from each other), a greater awareness of the each other’s professional roles (about each other), shared learning (with each other) and the benefit to patient care as a result of collaborative working all of which is consistent with theories associated with inter-professional learning (16).

**Conclusions**

The masterclass was positively received. This pilot adds to the literature on prescribing simulation and suggests that it has a positive effect on students’ confidence and appreciation of the expertise of others taking on a prescribing role. Furthermore the trust in physician score in a simulated environment appears to be a useful measurement instrument to obtain feedback from
patients. This study suggests outcome measures used were appropriate and have the potential to be used in larger groups of student prescribers. In conclusion this pilot study has demonstrated that an inter-professional masterclass is feasible and beneficial. Recommended next steps are to conduct a well-designed randomized control trial that evaluates a cohort of students who have participated in an inter-professional prescribing workshop compared to those that have received standard education. Using clear outcome measures which are linked to patient outcomes may establish the absolute value of this type of learning.
Declaration of conflicting interests
The Author(s) declare that there is no conflict of interest

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Box 1

Case scenarios

**Sepsis**

65 year-old woman (simulated patient) admitted to hospital with severe sepsis. The scenario required management of septic shock and prescribing of antimicrobial treatment according to local guidance.

**Community**

62 year-old woman (simulated patient) at a GP appointment for management of uncontrolled hypertension, uncontrolled type 2 diabetes and over anticoagulation. The scenario required review of patients’ current medication, evaluation of possible reasons for lack of efficacy and optimization of treatment following local guidelines.

**Polypharmacy**

80 year-old woman admitted to hospital due to confusion secondary to multiple medications. The scenario required review of her 10 medications for cerebrovascular disease, increased frequency and nocturia, depression and hypothyroidism.
### Tables

#### Table 1 - RIPLS scores pre and post masterclass for all participants

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<thead>
<tr>
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<th>Pre masterclass</th>
<th>Post masterclass</th>
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<tr>
<td>Item numbers</td>
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<td>1-12</td>
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<tr>
<td>Range of possible points</td>
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<td>12-60</td>
</tr>
<tr>
<td>Number of participants</td>
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<td>8</td>
</tr>
<tr>
<td>Mean(SD)</td>
<td>55.1(2.97)</td>
<td>59.8(0.46)</td>
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<tr>
<td>Range</td>
<td>52-60</td>
<td>59-60</td>
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#### Table 2 - RIPLS scores pre and post masterclass by professional group

<table>
<thead>
<tr>
<th>Professional group (n)</th>
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<th>Post-masterclass</th>
<th>p value</th>
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<tbody>
<tr>
<td></td>
<td>Mean(SD) Range</td>
<td>Mean(SD) Range</td>
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<tr>
<td>Medical students (2)</td>
<td>58.0 (2.83) 56-60</td>
<td>60 (0) 60</td>
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<td>Pharmacist IPs (3)</td>
<td>58.7 (1.15) 58-60</td>
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<tr>
<td>NMPs (3)</td>
<td>53.7 (2.08) 52-60</td>
<td>59.7 (0.58) 59-60</td>
<td>0.035</td>
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<tr>
<td>Overall</td>
<td>55.1 (2.97) 52-60</td>
<td>59.8 (0.46) 59-60</td>
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</table>

#### Table 3 - Self-efficacy scores pre and post masterclass for all participants
### Table 4 - Self-efficacy scores pre and post masterclass by professional group

<table>
<thead>
<tr>
<th>Professional group (n)</th>
<th>Pre-masterclass</th>
<th>Post-masterclass</th>
<th>p value</th>
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<tr>
<td></td>
<td>Mean(SD)</td>
<td>Mean(SD)</td>
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<tr>
<td></td>
<td>Range</td>
<td>Range</td>
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</tr>
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<td>Medical students (2)</td>
<td>110.0(12.73)</td>
<td>135.0(14.14)</td>
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<td>101-119</td>
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<tr>
<td>Pharmacist IPs (3)</td>
<td>152.7(0.58)</td>
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<td></td>
<td>152-153</td>
<td>152-159</td>
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<td>NMPs (3)</td>
<td>112.3(15.18)</td>
<td>139.7(4.62)</td>
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<td>96-126</td>
<td>137-145</td>
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<tr>
<td>Overall</td>
<td>126.9(23.37)</td>
<td>144.9(11.76)</td>
<td>0.010</td>
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<td>96-153</td>
<td>125-159</td>
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### Table 5 - Trust scores by professional group
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<th>Case 2 score</th>
<th>Mean</th>
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<td>76.5</td>
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<tr>
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<tr>
<td>Mean</td>
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