

# **EXTENDING INDEPENDENT NURSE PRESCRIBING WITHIN THE NHS in ENGLAND**

**A guide for implementation (2<sup>nd</sup> Edition – February 2004)**

***Department of Health***

# ***HOW TO USE THE GUIDE***

This guide has been prepared for:

- Nurse Prescribers
- Primary Care Trusts
- NHS Trusts
- Strategic Health Authority Directorates of Workforce
- Strategic Health Authorities
- Personal Medical Services Pilots
- General Practitioners
- NHS Walk-in Centres
- Community Pharmacies
- Out-of-Hours Care Providers
- PCT Chief Pharmacists/Pharmaceutical Advisors
- Higher Educational Institutions providing nurse education

It will be for Primary Care Trusts, NHS Trusts and Strategic Health Authority Directorates of Workforce to consider, in light of local priorities, which nurses in their area should undertake training for prescribing. This guide has been prepared to assist them. It may also be of interest to the Prison Healthcare Service, the Defence Medical Services and the independent healthcare sector.

The Guide can be found on the Department's website. All or part of the Guide may be reproduced at local level as required.

The DH website also contains other detailed information on the independent prescribing of medicines by nurses, including frequently asked questions, and is regularly kept up to date on all developments.

## CONTENTS

	Paragraph
<b>Introduction</b>	1
<b>Brief background to nurse prescribing in England</b>	2-3
<i>District Nurse and Health Visitor prescribers</i>	4-5
<i>Extended Formulary Nurse prescribers</i>	6
<b>Who may prescribe and what may be prescribed from the Extended Formulary</b>	
<i>Categories of nurses and midwives who may prescribe</i>	7
<i>What may be prescribed by Extended Formulary Nurse Prescribers</i>	8-9
<i>Midwives</i>	10
<i>Patient Group Directions</i>	11
<b>Nurse Prescribing and the BNF/Drug Tariff</b>	12
<b>Implementation Strategy</b>	
<i>Selection of nurses and midwives to be trained</i>	13-17
<i>DH funding for extending nurse prescribing</i>	18-19
<i>Non-NHS staff</i>	20-21
<i>Funding from other sources</i>	22
<b>Education and training</b>	
<i>The programme of training for Extended Formulary Nurse Prescribers</i>	23-31
<i>Continuing professional development</i>	32-34
<b>Good practice, ethics and issues common to all nurse and midwife prescribers</b>	
<i>Responsibility for prescribing decisions</i>	35-36
<i>Gifts and benefits</i>	37-39
<i>Stock items</i>	40
<i>Informing patients</i>	41
<i>Who to write prescriptions for</i>	42-47
<i>Prescribing for self, family and friends</i>	48
<b>Nursing records</b>	
<i>Noting prescribing in the nursing record: good practice</i>	49-51
<b>Adverse reaction reporting</b>	52
<b>Patient safety</b>	53
<i>Role of the National Patient Safety Agency</i>	54
<b>Legal and clinical liability</b>	
<i>Liability of employer and professional liability</i>	55

<i>Professional indemnity</i>	56
<b>Dispensing of prescribed items</b>	
<i>Dispensing doctors in primary care</i>	57-60
<b>Role of the pharmacist – advice on medicines</b>	61-63
<b>Verification of prescribing status</b>	
<i>Role of the pharmacist on verification of prescribing status</i>	64-66
<i>The NMC Voice Bank</i>	67
<b>Role of the PPA</b>	68
<b>Dispensing by appliance contractors</b>	69
<b>Urgent dispensing</b>	70
<b>Dispensing items against a nurse prescription in hospital Pharmacies</b>	71
<b>Budget setting and monitoring</b>	72
<i>Nurse prescribing monitoring information – primary care</i>	73
<i>Nurse prescribing monitoring in secondary care settings</i>	74-75
<i>Evaluation, audit and clinical governance of nurse prescribing</i>	76-78
<b>Annex A: Notification of prescriber details to PPA</b>	
<b>Annex B: Prescription forms</b>	
<b>Annex C: Policy statement – Record Keeping</b>	
<b>Annex D: The Nursing and Midwifery Council’s requirements for Extended Independent Nurse Prescribing and Supplementary Prescribing</b>	

## **Introduction : Scope of this guidance and effects of devolution**

1. This guidance sets out the steps that are needed to enable registered nurses and registered midwives in England to prescribe from the Nurse Prescribers' Extended Formulary, and provides information and advice on good practice. Although the legislation that permits the extension of prescribing responsibilities applies across the UK, it is for the devolved administrations in Scotland, Wales and Northern Ireland to decide on the pace of implementation in their areas. **[NB Where the term “Registered Nurse” is used throughout the remainder of this document it includes Registered Midwives]**

## **Brief background to nurse prescribing in England**

2. Following the introduction of the necessary legislation in 1992 and 1994, nurse prescribing for District Nurses and Health Visitors was first piloted in eight GP fundholding practices in 1994. It was expanded to a whole district community NHS Trust in 1996 and to a further community trust in each of the seven remaining regions in 1997.
3. Following this successful piloting, Ministers agreed that nurse prescribing for District Nurses and Health Visitors could be expanded throughout England.

### *District Nurse and Health Visitor prescribers*

4. DN and HV prescribers are able to prescribe from the Nurse Prescribers' Formulary for District Nurses and Health Visitors, which is tailored to the needs of patients in the community. The Formulary is set out in Part XVIIIB(i) of the Drug Tariff. The necessary training to enable DNs and HVs to prescribe from this Formulary is now integrated into University-based specialist practitioner programmes for new District Nurses and Health Visitors.
5. DNs and HVs are also eligible for consideration for training to qualify as prescribers from the Nurse Prescribers' Extended Formulary, where there is a service need for them to do so (see below). Higher Education Institutions offering the specific programme of training

to prescribe from the Extended Formulary may approve and accredit the nurse prescriber's prior learning (APL).

### *Extended Formulary Nurse Prescribers*

6. Following a 3 month consultation beginning in October 2000 with nursing, medical and pharmacy professional organisations, Ministers announced in May 2001 that nurse prescribing would be extended to more nurses and to a wider range of medicines.

### **Who may prescribe and what may be prescribed from the Extended Formulary**

#### *Categories of nurses and midwives who may prescribe*

7. To be legally eligible to prescribe from the Nurse Prescribers' Extended Formulary:-
  - (a) Prescribers must be a 1<sup>st</sup> level Registered Nurse or Registered Midwife; and
  - (b) The nurse's or midwife's name must be held on the professional register of the Nursing and Midwifery Council (NMC) with an annotation signifying that the nurse has successfully completed the specific programme of training for extended formulary nurse prescribing. The standards for that training are approved by the NMC.[See also paragraph 23-25 below]

#### *What may be prescribed by Extended Formulary Nurse Prescribers*

8. Following training, nurses prescribing from the Nurse Prescribers' Extended Formulary (NPEF) are able to prescribe all General Sales List and Pharmacy medicines currently prescribable by GPs under GPMS regulations, together with a list of Prescription Only Medicines (POMs), but only for specified medical conditions. The medical conditions for which Extended Formulary Nurse Prescribers may prescribe are set out in both the British National Formulary (BNF) and in Part XVIIIB(ii) of the Drug Tariff. Nurses should not prescribe independently outside of these listed conditions. The list of POMs that Extended Formulary Nurse Prescribers may prescribe for these specified conditions is also set out in the BNF and the Drug Tariff.

9. Nurse prescribers should not prescribe medicines independently for uses outside of their licensed indications (so-called 'off licence' or "off-label ), except for the listed medicines if used for palliative care. Guidance in the Nurse Prescribers' Extended Formulary will list the indications for which nurses may prescribe each medicine. Nurses' prescribing may also be limited by locally agreed formularies, for instance a local PCT formulary. In prescribing as in other areas of practice, nurses and midwives are bound by the NMC Scope of Professional Practice to act only within their competence. Individual nurses should therefore only prescribe from sections of the NPEF relevant to the areas of their clinical expertise.

### *Midwives*

10. The extension of prescribing to nurses and midwives does not affect the Exemptions for midwives under Medicines Act legislation, which allow midwives to supply or administer certain listed medicines.

### *Patient Group Directions*

11. Nurses may also continue to use Patient Group Directions for the supply and administration of medicines, where this is more appropriate to meet patients' needs.

### **Nurse Prescribing and the BNF/Drug Tariff**

12. Nurses able to prescribe from the Extended Formulary will receive a centrally funded copy of the BNF every six months. The Nurse Prescribers' Formulary for District Nurses and Health Visitors will continue to be published and made available to DN/HV prescribers biennially, with any amendments made available annually. A copy of the Drug Tariff is currently supplied to all nurse prescribers every six months by the Prescription Pricing Authority (PPA). The next distribution is due to take place in May/June 2004. This will be the final time that the Drug Tariff is distributed to nurses in hard copy. Thereafter nurses will be able to access the Drug Tariff through the PPA websites [www.ppa.nhs.uk](http://www.ppa.nhs.uk) or [www.ppa.org.uk](http://www.ppa.org.uk)

## **Implementation strategy**

### *Selection of nurses and midwives to be trained*

13. In addition to fulfilling the legal criteria for eligibility to prescribe, applicants for the prescribing training will need:
  - The ability to study at Level 3 (degree level)
  - At least three years' post-registration clinical nursing experience (or part-time equivalent) : nominees will usually be at E grade or above
  - A medical prescriber willing to contribute to and supervise the nurse's 12 day learning in practice element of training (see below)
  - The support of their employer to confirm that
    - their post is one in which they will have the need and opportunity to prescribe from the Extended Formulary;
    - for nurses in primary care, they will have access to a prescribing budget on completion of the course
    - they will have access to continuing professional development (CPD) opportunities on completion of the course.
  
14. There are likely to be many nurses in any local health economy who meet these criteria. The three key principles that should be used to prioritise potential applicants are:
  - patient safety
  - maximum benefit to patients in terms of quicker and more efficient access to medicines for patients
  - better use of nurses' skills
  
15. The extension of nurse prescribing is intended to bring benefits beyond community and primary care, and so it is expected that nominees for the DH-funded training will come from secondary care as well as primary care settings. However, the selection of



individuals who will receive prescribing training from among those eligible is entirely a matter for local decision, in the light of local NHS needs and circumstances.

16. No nurse should be required to undertake training unless he/she wishes to do so.
17. The nurse prescribing lead in each Strategic Health Authority Directorate of Workforce will be able to liaise with NHS employers and Higher Education Institutions to ensure that applicants and course places can be appropriately matched. A list of Directorate of Workforce leads can be found on the Department's website at [www.dh.gov.uk/nurseprescribing](http://www.dh.gov.uk/nurseprescribing).

#### *DH funding for extending nurse prescribing*

18. DH funding is allocated to Strategic Health Authority Directorates of Workforce to meet the cost of training nurses in prescribing. This funding is intended to benefit patients and improve their access to medicines on the NHS. Training for nurses employed by **all** NHS bodies can therefore be funded from this resource.
19. Funding to Strategic Health Authority Directorates of Workforce is currently allocated on the basis of the numbers of qualified nurses, midwives and health visitors in the Directorate of Workforce area. The annual allocation letter will indicate the numbers of nurses that the Department expects to be trained in prescribing over the course of the year, which is linked to the level of funding allocated. It is, however, the responsibility of each Directorate of Workforce to determine the detail of how best to use the funds made available to it.

#### *Non-NHS staff*

20. Nurses employed by non-NHS organisations, and who provide the majority of their services to NHS patients (e.g. nurses working in hospices) may have their training funded from the funding referred to in paragraph 19 above.

21. In nominating for training any nurses whose posts are directly or indirectly funded by pharmaceutical and other companies whose products may appear in the Nurse Prescribers' Extended Formulary, employers should be aware of, and take any necessary steps to ameliorate, any conflicts of interests that may subsequently arise in the nurse's practice. Nurses are reminded of clause 16 in the Code of Professional Conduct which states that, in the exercise of his/her professional accountability, a registered nurse must 'ensure that your registration status is not used in the promotion of commercial products or services, declare any financial or other interests in relevant organisations providing such goods or services, and ensure that your professional judgement is not influenced by any commercial considerations'.

#### *Funding from other sources*

22. If it so wishes, an NHS organisation or a private organisation may pay for the training of more nurses and midwives through other sources of funding (e.g. existing training budgets).

### **Education and Training**

#### *The programme of training for Extended Formulary Nurse Prescribers*

23. An outline curriculum for training and preparation for Extended Formulary nurse prescribing was produced by the former English National Board for Nursing and Midwifery (ENB) in September 2001. This is available on the DH nurse prescribing website [www.dh.gov.uk/nurseprescribing](http://www.dh.gov.uk/nurseprescribing). The Department of Health, the former UKCC and the ENB issued information about the future of this course and other "ENB" courses, in preparation for the closure of the ENB. This was published in the form of letters sent to all Strategic Health Authority Directorates of Workforce and Higher Education Institutions running nursing and midwifery programmes on 8 November 2001 and 22 March 2002. Copies of these letters are also available on the nurse prescribing website. The letters indicate: *"The NMC will apply the ENB's existing standards and associated guidance for the approval of higher education institutions in respect of registerable and recordable programmes, until such time as it determines new standards and guidance."*

24. The Nursing and Midwifery Council has now determined a **new** standard in respect of Independent Prescribing (for the Extended Formulary) and Supplementary Prescribing, and will only validate new recordable courses against that standard. The NMC standards are at Annex D to these Guidelines.
25. A single training course now enables a nurse to qualify as both independent nurse prescriber and supplementary nurse prescriber. The additional training for supplementary prescribing will take between one and two days and therefore the length of a combined course should be at least 26 taught days, plus 12 days learning in practice with a supervising medical practitioner. Of the taught element, a significant proportion should be face-to-face contact time. However other ways of learning, such as open and distance learning formats, may now also be considered. The proportion of face to face contact time is for consideration between the HEI and the NMC.
26. The training programme includes an assessment of theory and practice that must be passed before the student's entry on the NMC register is annotated, to indicate that they hold the prescribing qualification for nurse prescribing.
27. Courses that have been modified (for example to allow for the inclusion of open and distance learning) will need to be re-validated by the NMC. In all such cases, the NMC requires confirmation that modifications to existing Extended Formulary nurse prescribing courses incorporating the additional requirements for supplementary prescribing have been approved internally, prior to the course being offered.
28. The responsibility for the content of the detailed curriculum of the integrated course lies with the commissioner of the course. DH expects course commissioners and validators to approve only those courses which demonstrate content that is consistent with published guidance and that the learning outcomes of the curriculum are to be achieved.
29. The course for Extended Formulary Nurse Prescribers attracted 20 CATS points. How many CATS points the amended course should attract is a matter for HEIs, in discussion with the commissioning Strategic Health Authority Directorate(s) of Workforce. This is

essentially an issue of standards and levels of learning. HEIs and Directorates of Workforce will wish to keep in mind, in the light of credit transfer considerations, the need for consistency in the amount of credit that courses attract. It is expected that HEIs modifying existing courses will only adjust the credit awarded to acknowledge additional learning related to supplementary prescribing.

30. Individual Higher Education Institutions, where appropriate, may use approved prior learning (APL), to give credit for a nurse's previous learning.
31. Many Universities, and some pharmaceutical companies, offer training and education in aspects of pharmacology and medicines management. However only nurses who successfully undertake an NMC approved programme of training for nurse prescribing will have their qualification recorded on the NMC Register.

#### *Continuing Professional Development (CPD)*

32. All nurses and midwives have a professional responsibility to keep themselves abreast of clinical and professional developments. This is no less true for nurse prescribing. Prescribers will be expected to keep up to date with best practice in the management of the conditions for which they may prescribe, and in the use of the medicines on the Nurse Prescriber's Extended Formulary. They may use the learning from this activity as part of their Post Registration Education and Practice (PREP-CPD) activity. The employer should ensure that the practitioner has access to relevant education and training provision. Details of additional training and updating will need to be incorporated by the individual into their personal professional profile, in order to renew their registration with the NMC.
33. Nurse prescribing should be introduced and take place within a framework of clinical governance. This means that it will be aligned to patient need, incorporate the best available evidence, be underpinned by education, training and continued professional development, be subject to regular audit and evaluation, be risk-assessed and help the employing organisation meet its strategic goals for improving patient care. Clinical supervision sessions provide a formal opportunity for reflection on prescribing and other

aspects of practice. The model of clinical supervision should be agreed at local level, and its effectiveness monitored and evaluated regularly.

34. The National Prescribing Centre has produced a document “Maintaining competency in prescribing: an outline framework to help nurse prescribers”. This is available from the National Prescribing Centre in Liverpool or on the NPC’s website [www.npc.ppa.nhs.uk](http://www.npc.ppa.nhs.uk). This can be used by nurses training to prescribe, newly-qualified and more experienced nurse prescribers, their employers and managers, as a tool to help reflect on practice and identifying CPD needs.

### **Good practice, ethics and issues common to all nurse and midwife prescribers**

#### *Responsibility for prescribing decisions*

35. A nurse prescriber can only order a medicine for a patient whom he/she has assessed for care. In primary care, a nurse should only write prescriptions on a prescription pad bearing his/her own unique identifier number.
36. In the absence of the patient's original nurse prescriber, another nurse prescriber may issue a repeat prescription or order repeat doses following an assessment of need, and taking into consideration continuity of care. Accountability for any prescription or order for medicines rests with the nurse who issues that prescription or order for medicines. A qualified nurse prescriber may also give patient specific directions for the administration of any medicine that is included in the Extended Formulary. The prescribing nurse will clearly need to be satisfied that the person to whom s/he gives the instructions is competent to administer the medicine concerned.

#### *Gifts and benefits*

37. The advertising and promotion of medicines is strictly regulated under the Medicines (Advertising) Regulations 1994, and it is important that nurse prescribers, and indeed all

health professionals, make their choice of medicinal product for their patients on the basis of clinical suitability and value for money alone.

38. As part of the promotion of a medicine or medicines, suppliers may provide inexpensive gifts and benefits, for example pens, diaries or mouse mats. Personal gifts are prohibited, and it is an offence to solicit or accept a prohibited gift or inducement. Companies may also offer hospitality at a professional or scientific meeting or at meetings held to promote medicines, but such hospitality should be reasonable in level and subordinate to the main purpose of the meeting.
39. The Medicines and Healthcare products Regulatory Agency (MHRA) is responsible for enforcing the legislation on advertising and promotion of medicines. Any complaints about promotional practices should be referred to the MHRA or to the industry self-regulatory body, the Prescription Medicines Code of Practice Authority.

#### *Stock items*

40. In primary care settings, nurse prescriptions should not be written when an item has been administered to a patient using GP surgery or clinic stock items, because the cost of these items is already covered from other budgets. The exception is in circumstances where the medical practitioner is eligible for direct reimbursement. These items are listed in the Statement of Financial Entitlements, which carries forward paragraph 44.5 of the Statement of Fees and Allowances of NHS General Medical Services. When prescribing any of these items for personal administration the prescriber should endorse "PA" on the front of the prescription form. Claims for specified high volume personally administered vaccines must be made as bulk entries on the relevant version of the prescription invoice form FP34 and FP34 (Appendix), following current instructions.

#### *Informing patients*

41. Nurse prescribers must ensure that patients are aware of the scope and limits of nurse prescribing and how the patient or client can obtain other items necessary for their care.

### *Who to write prescriptions for*

42. Practice nurse prescribers may only issue prescriptions for the patients registered with their GP practice. PMS pilot nurses may only issue prescriptions for patients registered with that pilot.
43. Nurses employed by a PCT may only issue prescriptions for the patients of GP practices within the PCT. In addition, if they are involved in providing services through a Community Nurse Prescribing Contract, they can issue prescriptions for the patients of GP practices covered by the contract and for which a prescribing budget has been agreed.
44. Nurses employed by a NHS Trust who are prescribing in primary care on behalf of a PCT can only issue prescriptions for the patients of the GP practices covered by a Community Nurse Prescribing Contract and for which a prescribing budget has been agreed.
45. Practice nurses should only prescribe for the visiting relatives of patients if those relatives are temporarily registered with the GP (GP practice from April 2004) concerned.
46. Nurses can prescribe for travelling families, provided that the appropriate residency forms have been completed.
47. Nurses and midwives in secondary care settings should only prescribe for patients in the clinic or ward in which they are working or for patients in their area of clinical responsibility (eg where hospital based nurses provide services in the community as part of an outreach team).

### *Prescribing for self, family and friends*

48. Registered nurses and registered midwives are accountable for their practice at all times. If a situation arises where they find themselves in a position to prescribe for themselves or their family, then they must accept accountability for that decision. It is strongly

recommended that (as for doctors and dentists) nurses should avoid prescribing for themselves or close family members, as judgement may be impaired and important clinical examination may be impossible.

## **Nursing Records**

### *Noting prescribing in the nursing record: good practice*

49. All nurses are required to keep contemporaneous records, which are unambiguous and legible. The NMC Standards for Records and Record Keeping outline the requirements of a nurse's records. The record of the nurse's or midwife's prescription, together with other details of the consultation with the patient, should be entered into the patient record (and the nursing patient record where such a separate record exists) as soon as possible and preferably contemporaneously. It should be marked to indicate that it is a nurse prescription and should include the name of the prescriber. The maximum time to be allowed between writing the prescription and entering the details into the general record is for local negotiation, but best practice suggests that this should be immediately. Only in exceptional circumstances (e.g. the intervention of a weekend or public holiday) should this period exceed 48 hours from writing the prescription. Arrangements for the sharing of patient records can be put into locally agreed statements of good practice.
  
50. It is recommended that the record clearly indicates the date, the name of the prescriber, the name of the item prescribed and the quantity prescribed (or dose, frequency and treatment duration). For medicinal preparations, items to be ingested or inserted into the body, it is recommended that the name of the prescribed item, the strength (if any) of the preparation, the dosing schedule and route of administration is given e.g. "paracetamol oral suspension 120mg/5mls, 5mls to be taken every 4 hours by mouth as required for pain, maximum of 20mls in 24 hours". For topical medicinal preparations, the name of the prescribed item, the strength (if any), the quantity to be applied and frequency of application should be indicated. For dressings and appliances, details of how they should be applied and how frequently they should be changed are useful. It is recommended that the advice given on General Sales List (also known as "Over The Counter") items is recorded, although this is not mandatory.



51. In some circumstances, in the clinical judgement of the nurse prescriber, it may be necessary to advise the GP or consultant immediately about the prescription. This action should be recorded in the common patient record.

### **Adverse Reaction Reporting**

52. If a patient suffers a suspected adverse reaction to a prescribed, over-the-counter (Pharmacy or General Sales List) or herbal medicine, the adverse reaction should be reported via the Yellow Card Scheme. The Yellow Card Scheme is a voluntary scheme through which healthcare professionals (including nurses and midwives) notify the Medicines and Healthcare Products Regulatory Agency (MHRA)/Committee on the Safety of Medicines (CSM) of suspected adverse drug reactions. The MHRA/CSM encourage the reporting of all suspected adverse drug reactions to newly licensed medicines that are under intensive monitoring (identified by an inverted black triangle both on the product information for the drug and in the BNF and MIMS) and all serious suspected adverse drug reactions to all other established drugs. Serious reactions include those that are fatal, life threatening, disabling, incapacitating or which result in or prolong hospitalisation and/or are medically significant. The new electronic Yellow Card provides a simple and fast way to report suspected adverse reactions. The electronic Yellow Card, together with instructions on how to use it, is available on the MHRA website ([www.mhra.gov.uk](http://www.mhra.gov.uk)). Health professionals are encouraged to report all suspected adverse drug reactions using this method, although hard copy Yellow Cards are also acceptable (and can be found at the back of the British National Formulary). [A supplementary prescriber should also inform the independent prescriber of any reported ADRs].

### **Patient Safety**

53. The bulletin "Current Problems In Pharmacovigilance", issued by the MHRA and the CSM, contains advice and information on drug safety issues. The bulletin is produced four times a year. All nurse prescribers are encouraged to consult the bulletin as a matter of routine. Copies are also available from the CSM's website, which can be found on

[www.mhra.gov.uk](http://www.mhra.gov.uk). Nurses should also ensure that they are fully aware of the section of the Home Office's Misuse of Drugs Regulations dealing with the storage of Controlled Drugs and of any local policies on this issue.

### *Role of the National Patient Safety Agency*

54. If a patient suffers harm due to any adverse incident, including those involving medicines, or if harm could have been caused to the patient (a "near miss"), the incident or near miss should be reported by the nurse prescriber using both local and national reporting systems. The National Patient Safety Agency (NPSA), a special health authority, was established in 2001 to improve the safety of NHS patient care, by promoting a culture of reporting and learning from adverse incidents across the NHS. The Agency has developed, and is implementing and managing a new reporting system to collect information on patient safety incidents (including near misses) so that lessons can be learned at local and national level. It will develop solutions to try to ensure that the same errors are not repeated. Following a period of testing and development, the NPSA has begun to implement the National Reporting and Learning System (NRLS). The system is being rolled out across the NHS in England and Wales from November 2003 until December 2004. Further information on the NPSA can be found on its website [www.npsa.nhs.uk](http://www.npsa.nhs.uk).

## **Legal and Clinical Liability**

### *Liability of employer and Professional Liability*

55. Where a nurse or midwife is appropriately trained and qualified and prescribes as part of his/her professional duties with the consent of their employer, the employer is held vicariously liable for his/her actions. In addition, nurse prescribers are individually and professionally accountable to the NMC for this aspect of their practice, as for any other, and must act at all times in accordance with the NMC Code of Professional Conduct and Scope of Professional Practice.

### *Professional indemnity*

56. All nurse and midwife prescribers should ensure that they have professional indemnity insurance, for instance by means of membership of a professional organisation or trade union.

### **Dispensing of prescribed items**

#### *Dispensing Doctors in primary care*

57. Where a GP practice is a dispensing practice, nurse prescriptions can be dispensed by the practice but only for the dispensing patients of that practice. Dispensing Doctors cannot dispense prescriptions written by nurses for patients of other practices.
58. When submitting prescription forms to the Prescription Pricing Authority, dispensing practices should follow the sorting instructions on the prescription invoice – Form FP34D.
59. Reimbursement for nurse prescriptions can be claimed by Dispensing Doctors and payment for the prescriptions submitted will be made to the senior partner.
60. If any items dispensed are subsequently found not to be on the Secretary of State's list for District Nurses and Health Visitors as set out in the Drug Tariff or the Nurse Prescribers' Formulary for District Nurses and Health Visitors, they will not be reimbursed.

### **Role of the pharmacist – advice on medicines**

61. Pharmacists are a very useful source of help and advice to any prescriber. They can advise on pharmacology, drug dosages, product selection and side effects. They will also know the costs, availability and pack sizes of prescribed items.
62. Community pharmacists will expect to see:

- primary care nurse prescriptions on either FP10P (hand written prescriptions) or FP10SS (where prescriptions are generated by a surgery's computerised prescribing system). See also Annex B, paragraphs 8 and 9.
- Hospital based nurse prescriptions on hand-written FP10HP or FP10NC or printed on FP10SS (when prescriptions are generated by a hospital computerised prescribing system). See also Annex B paragraph 12.

63. Nurse or midwife prescribers should be aware that pharmacists have legal and ethical obligations which mean they may need to contact prescribers - sometimes urgently - to confirm an aspect of the prescription, return it for amendment or even to refrain from dispensing it. An up-to-date contact telephone number should be included (in the address box) on all prescriptions.

### **Verification of prescribing status**

#### *Role of the pharmacist on verification of prescribing status*

64. The dispensing pharmacist will need to be sure that the prescriber has qualified as an independent nurse prescriber. In the case of District Nurse/Health Visitor prescribers, the pharmacist will also need to check that the medicines or appliances prescribed are included in the Nurse Prescribers' Formulary for District Nurses and Health Visitors.
65. The prescription form will indicate whether a nurse is an Extended Formulary Nurse Prescriber/Supplementary Prescriber. It will not be possible for a dispensing pharmacist to check whether a nurse is prescribing as an Extended Formulary Nurse Prescriber or as a Nurse Supplementary Prescriber, as the nurse will more often than not be qualified as both and there is no list of medicines for supplementary prescribers. As stated above, the dispensing pharmacist will, of course, need to use his/her professional judgement, as for doctors' prescriptions, to assess whether a prescription is appropriate for a particular patient.

66. To enable pharmacists to check whether a prescription handed in for dispensing is bona fide, **all** NHS employers should keep a list of all nurse prescribers employed by them. It is also recommended that the employing authority holds a copy of the prescriber's signature. Individuals should be prepared to provide specimen signatures to pharmacists, should that be required.

#### *The NMC Voice Bank*

67. Most enquiries from dispensing pharmacists will be resolved by telephoning the prescriber, the prescriber's employer or the PCT. However, for general queries about qualification (e.g. in the case of receiving a private prescription), the pharmacist can telephone the 24-hour NMC voice bank system (telephone number 020 7631 3200). Pharmacists should clearly state that they are checking the prescribing status of an individual. They should then be asked to give the nurse prescriber's NMC number and name. If the pharmacist fails to state that he/she is checking prescribing status, the NMC operator will assume the pharmacist is the nurse's employer and will ask a number of further questions to which the pharmacist will not have the answer.

#### ***Role of the PPA***

68. The PPA will only check to ensure that prescriptions written by a District Nurse/Health Visitor prescriber are restricted to items included in the DN/HV Formulary. For the reasons set out in paragraph 65 above, it will not be possible for the PPA to check whether a nurse is prescribing as an Extended Formulary or Supplementary Prescriber.

#### **Dispensing by appliance contractors**

69. When a nurse becomes aware that the patient intends to have a prescription dispensed by an appliance contractor, he/she must ensure that the prescription does not contain medicinal preparations. Appliance contractors should follow the instructions on the Prescription Invoice – Form FP34A - when sorting prescription forms prior to sending

them to the PPA for pricing. NB Appliance contractors cannot dispense medicinal preparations.

### **Urgent dispensing**

70. Occasionally a nurse prescription may require dispensing out of normal pharmacy opening hours. Many pharmacies are now open out of hours, and the local NHS Direct centre should have a list of those that do. If a medicine is required urgently and there is no local pharmacy open, the prescription form should be endorsed by the prescriber with the word "Urgent". The local police also normally hold information on pharmacies that provide an "urgent" service.

### **Dispensing items against a nurse prescription in hospital pharmacies**

71. An up-to-date list of all qualified nurse prescribers employed by the hospital will need to be kept in the hospital pharmacy. Pharmacy staff should check the prescriber against the list. The same process will apply for in-patient, outpatient and discharge prescriptions.

### **Budget Setting and Monitoring**

72. The Department of Health has issued detailed guidance to inform all those involved in allocating resources and local budget setting for years up to 2004/5. This is available on three websites:

- PCT ([www.dh.gov.uk/pricare/pcts.htm](http://www.dh.gov.uk/pricare/pcts.htm));
- Finance Manual ([www.dh.gov.uk/finman.htm](http://www.dh.gov.uk/finman.htm)); and
- Prescribing Support Unit (PSU) ([www.psu.ppa.nhs.uk](http://www.psu.ppa.nhs.uk)).

#### *Nurse prescribing monitoring information - primary care*

73. The PPA reimburses costs to dispensing contractors and provides essential information, both electronically and via paper reports, to authorised users. Nurse Prescribers can expect to receive information via their PCT, GP Practice, PMS Pilots, Walk-in Centres and Out of Hour Care Providers which will help to monitor their prescribing. Prescribing

by nurse supplementary prescribers will also be included in nurse prescribing data. Individual nurse prescriber PACT Catalogues (giving details down to individual presentation and prescription quantity level) are only available on request. Requests from the nurse prescriber's employer should be made on headed notepaper to:-

PPA  
Prescriber Information  
Prescription Pricing Authority  
Scottish Life House  
Archbold Terrace  
Jesmond  
Newcastle upon Tyne  
NE2 1DB

#### *Nurse prescribing monitoring in secondary care settings*

74. Hospital employers may find it beneficial to collect and analyse prescribing data on nurse prescribers alongside the routine monitoring of prescribing by doctors.
75. Prescribing by individual nurses will need to be considered within the context of the clinical team to which they are attached. It may be appropriate to give the senior nurse or pharmacist in the team the responsibility for monitoring prescribing by nurses within each team.

#### *Evaluation, Audit and Clinical Governance of Nurse Prescribing*

76. The nurse prescriber's employer must put in place specific actions regularly to evaluate the safety, effectiveness, appropriateness and acceptability of their prescribing.
77. In addition to the central and local systems for monitoring the number and cost of items prescribed by nurse and midwife prescribers, each prescriber is responsible for his/her individual practice, and must carry out regular reviews of his/her prescribing practice and take part in the clinical governance activities of their employing organisation.

78. Assistance with identifying audit methodologies and interpreting findings should be available through the employing organisations' normal clinical governance mechanisms.

Department of Health  
Medicines, Pharmacy and Industry Group  
February 2004



## ANNEX A

### NOTIFICATION OF PRESCRIBER DETAILS TO PPA

1. The details of nurse prescribers employed by a NHS Trust, PCT, GP practice, PMS pilot, Walk in Centre or Out of Hours Care provider must be registered with the PPA before pre-printed prescriptions for that prescriber can be ordered. There is currently no requirement to notify the PPA of changes to the details of hospital-based nurse prescribers (see also Annex B).
2. Notification of required details by the prescribers' employer to the Prescription Pricing Authority (PPA) enables the setting up of automatic monitoring processes as well as allowing the provision of prescriber details (currently primary care prescribers only) to the supplier (currently Astron) for the printing of prescription pads.
3. Employers of all nurse prescribers practising in primary care are therefore required<sup>1</sup> to inform the PPA of the nurse prescriber's details using one of the following revised PPA Annex forms which are available on the PPA website [www.ppa.nhs.uk](http://www.ppa.nhs.uk):
  - PPA Annex A1 – For use by NHS Trusts in respect of nurse (and supplementary) prescribers they employ who are prescribing within a Community Nurse Prescribing Contract;
  - PPA Annex A2 – For use by PCTs in respect of nurse [and supplementary] prescribers employed by a GP practice, PMS pilot, Walk in Centre or Out of Hours Care provider;
  - PPA Annex A3 – For use by PCTs in respect of nurse (and supplementary) prescribers directly employed by the PCT (including circumstances where the PCT is contracted to provide nursing services to other commissioning organisations through a Community Nurse Prescribing Contract)

---

<sup>1</sup> Paragraph 8 of Schedule 2 to the NHS Act 1990 provides that "an NHS trust shall furnish to the Secretary of State such reports, returns and other information, including information as to its forward planning, as, and in such form as, he may require". In this case the Secretary of State is intending to require NHS trusts to furnish information direct to the Prescription Pricing Authority, in the manner prescribed on the official proforma.

4. The PPA Annex forms should also be used to notify the PPA of changes in circumstances (e.g. name) as they occur.
5. In order to avoid transposition errors, and the subsequent problems incurred, the PPA Annex forms should be completed electronically by the relevant personnel within each Primary Care Trust and NHS Trust and then either:

emailed to [val.peel@ppa.nhs.uk](mailto:val.peel@ppa.nhs.uk) or

printed and sent to:

PPA, Prescriber Information,  
Scottish Life House,  
Archbold Terrace,  
Jesmond,  
Newcastle upon Tyne, NE2 1DB.

6. The detail asked for on the PPA Annex forms has been kept to a minimum to reduce work for the employer. Collecting and transmitting the information will, however, require co-operation and this should ideally be discussed at the implementation stage, if such systems are not already in place. The details asked for on the PPA Annex forms include the:
  - nurse prescriber's "personal identification number" – provided by the NMC
  - nurse prescriber's name
  - organisation for which the nurse prescriber works (where relevant)
  - organisation details

#### *Changes to prescriber details*

7. It is the responsibility of employers of nurse prescribers who are registered with the PPA and who are working in PCTs, PMS Pilots, Walk-In Centres and Out of Hours Care providers, to ensure that changes to the prescribers' details are notified to PPA as soon as they occur, e.g. change of name on marriage, change of telephone number. Failure to do this will mean

that prescription forms will continue to be produced with the former (incorrect) details on them.

8. GP practice, PMS Pilot, Walk in Centre or Out of Hours Care provider employers of nurse prescribers in primary care, should pass details to the relevant Primary Care Trust within 48 hours (excluding weekends or Bank Holidays). The Primary Care Trust will then be responsible for passing the details to the PPA using the relevant PPA Annex form.

*Prescriber ceases employment / prescribing.*

9. The employer should inform the PPA as soon as possible when a nurse prescriber is no longer carrying out prescribing duties (for example, because he/she has changed employer, moved to a different non-prescribing job with the same employer, been suspended from the register or had his/her approval as a prescriber withdrawn for some reason). They should do this by submitting the relevant PPA Annex form. This includes circumstances where the employer is contracted to provide services for other commissioning organisations, e.g. nursing services through a Community Nurse Prescribing Contract.
10. PCTs should annotate their lists of nurse prescribers with the reasons for any changes, to ensure that an up-to-date record exists.

## **ANNEX B**

### **PRESCRIPTION FORMS**

1. All prescription forms require information to be entered on them (by printing or writing or combination of both). In addition to the correct dispensing of the items prescribed, this allows for prescribing information and costs to be attributed to the correct prescriber and / or organisation and to the correct prescribing budget (for further information on budget setting and monitoring see paragraphs 72-75 of this Guide). Nurses should ensure that when they prescribe on FP10 prescription forms, they use the correct type (i.e. with correctly printed personal and prescriber details) to ensure accurate prescription data and allocation of prescribing costs. Further information is set out below.

### **ORDERING PRE-PRINTED PRESCRIPTION FORMS**

#### *Ordering prescription forms*

2. Employers should note that prescription forms are not sent out automatically. FP10 prescriptions must be ordered from the supplier (Astron). Prescriptions should also be re-ordered from Astron as and when required.
3. Orders for new prescribers' prescription forms should not be placed earlier than 42 days prior to the date the individual is scheduled to begin prescribing for your organisation, as Astron cannot access PPA data before this point.
4. Allow at least 6 working days between notifying changes to the PPA and ordering prescriptions. This will allow time for data input and transmission of updated data files to Astron. Details on orders must match PPA data held by Astron. If you order too quickly after changing the details – the order may be rejected; any orders based on details which conflict with data held by Astron will be rejected for security reasons.

5. For security reasons, prescriptions are only sent to authorised delivery points (PCT or PCT Agency Form Supply Unit or e.g. Hospital Pharmacy). However, an alternative address can be specified for invoicing purposes. Checks are made to ensure that FP10 prescriptions are only supplied to bona-fide NHS organisations. The PCT, Agency or hospital pharmacy is responsible for the secure distribution of forms to individual prescribers. Difficulties with prescription orders should be addressed, in the first instance, to the supplier Astron.

*Prescription forms FP10P pre-printed by Astron.*

6. The top of the prescribing area will be overprinted to identify the type of nurse prescriber eg:

- EFNP/NURSE SUPPLEMENTARY PRESCRIBER, or
- DISTRICT NURSE/HEALTH VISITOR PRESCRIBER

7. The address box will be overprinted to identify:

- the nurse prescriber,
- the organisation they are prescribing on behalf of, and
- for those nurse prescribers who are directly employed by a PCT or prescribing through a Community Nurse Prescribing Contract, a space for the relevant practice number to be added for each patient for whom they prescribe.

8. Information about prescription overprinting and single sheet versions of the FP10P will be available on the Department of Health web page [www.dh.gov.uk/prescriptionform](http://www.dh.gov.uk/prescriptionform), which will be updated from time to time.

9. When FP10SS are generated by a primary care nurse prescriber, the prescribing system must be correctly configured to print required nurse details. Prescribing software suppliers have action in hand to enable nurses to prescribe using the GP computer system. See [www.dh.gov.uk/prescriptionform](http://www.dh.gov.uk/prescriptionform) or contact your prescribing software supplier for more information.

10. Any prescriber who works for more than one employer or in more than one setting eg

- i) – PCT directly employed prescriber providing services to those patients in the PCT and
- ii) – the same prescriber providing services to patients external to the PCT through a contract

**must** have a separate prescription for each organisation, with the correct organisation in the address box area of the prescription form.

## **PRESCRIBING BY HOSPITAL BASED NURSE PRESCRIBERS**

11. Nurse prescribers prescribing for hospital in-patients or outpatients may use three methods to prescribe:

- Hospital in-patient prescription form or sheet – to be used for in-patients and discharge supplies only. A prescription charge is not levied for in-patients.
- Internal hospital prescription form – to be used for out patients but only in cases where the hospital pharmacy will dispense the prescription. A prescription charge is payable, unless the patient is exempt from such a charges. **(NB internal hospital forms cannot be accepted for dispensing by community pharmacies).**
- FP10 type prescription forms, **where the medicine will be prescribed by a hospital prescriber and dispensed by a community pharmacist.** (Note: the Prescriber's employer should establish a local policy on the use of prescription forms in these circumstances.)

12. There is currently no requirement to notify the PPA of changes to the details of hospital-based nurse prescribers

### *Ordering prescription forms*

13. Managers of hospital based nurse prescribers should order FP10 forms as required. **FP10** type prescriptions for a hospital based nurse should conform to community pharmacist and PPA processing requirements and be printed with prescribing account codes approved by

the PPA. Where possible, they should also identify the type of nurse prescriber at the top of the prescribing area eg

- EFNP/NURSE SUPPLEMENTARY PRESCRIBER

PIN ..... or

- DISTRICT NURSE/HEALTH VISITOR PRESCRIBER

PIN .....

For further details of what should be stamped / printed on these forms prior to issue to the prescriber and the latest guidance on form use for hospital-based prescribers switching over to "green" FP10 forms, see DH web site [www.dh.gov.uk/prescriptionform](http://www.dh.gov.uk/prescriptionform)

## **NON-NHS EMPLOYEES**

14. A non-NHS nurse prescriber cannot issue an FP10 type prescription, i.e. one which will be dispensed in a NHS community pharmacy, unless the organisation they work for has an arrangement / contract with an NHS provider (e.g. PCT) which allows the non-NHS organisation to use NHS community pharmacy dispensing services. The NHS provider should organise the supply of FP10 type prescription forms (and obtain the prescribing code(s) to be used) for the non-NHS organisation, if this is appropriate.

## **HOW TO COMPLETE THE PRESCRIPTION FORM**

15. Detailed advice on prescription writing is contained in the Nurse Prescribers' Formulary and the British National Formulary (BNF).

16. Details required on the front of the prescription form (to be entered by writing clearly and legibly using an indelible pen (preferably black) or, where possible, by printing using a computer prescribing system) are:

- the patient's title, forename, surname and address (including postcode) and if available the patient's NHS number.
- Age and date of birth (must be printed by GP computer prescribing systems; for hand written prescriptions - enter if known e.g. from patient notes - BUT it is a legal requirement to write the patient's age on the prescription when prescribing Prescription Only Medicines for a child under twelve years of age).
- for prescribing in primary care and in the community, the prescription should contain the name of the prescribed item, formulation, strength (if any) dosage and frequency, and quantity to be dispensed. The quantity prescribed should be appropriate to the patient's treatment needs, bearing in mind the interval before the patient's condition is to be reviewed, the need to avoid waste, patient convenience and the avoidance of undue quantities of potentially poisonous substances in the home. Some medicines are only available in patient packs (or multiples thereof)<sup>2 3</sup> and special containers<sup>4</sup> and the quantity contained should be prescribed, provided this is clinically and economically appropriate. The quantity should be specified for solid preparations as number of dose-units (number of tablets, capsules, lozenges, patches etc), for liquid measures in millilitres (mL or ml), for topical preparations by mass (grams, g) or volume (millilitres, mL or ml). Alternatively, for preparations to be given at a fixed dose and interval, the duration(s) of treatment can be given in place of quantity to be dispensed.
- In hospitals, prescriptions for in-patients should contain the name of the prescribed item, formulation, strength (if any), dosage and frequency. Where a defined length of treatment is required this should be stated. For outpatients and discharge prescriptions, the requirements are the same as those for primary/community care, whilst recognising local policies for example on the length of treatment provided for outpatients and patients who are being discharged.

---

<sup>2</sup> A patient pack is a manufacturer's pack approved by the Licensing Authority which has a label and leaflet and contains an amount of medicine such that the pack is capable of being given whole to a patient to meet all or part of a treatment course. For some medicines special packs containing smaller quantities will be available for starter/titration/trial purposes.

<sup>3</sup> In the BNF, pack size is indicated as in this example "Net price 60-tab pack=£2.25". Wherever no pack size is indicated, as in "Net price 20=9p, the quantity is shown for price comparison purposes only.

<sup>4</sup> A special container is a pack from which it is not practicable to dispense an exact quantity, or a pack with an integral means of application. This currently includes sterile preparations, effervescent or hygroscopic products, liquid preparations which are intended to be added to bath water, coal tar preparations, viscous preparations and all products packaged in casters, tubes, dropper bottles, aerosols, puffers, roll-on packs, sachets, sprays, shakers, squeeze packs.



- The names of medicines should be written clearly. Nurses are recommended to prescribe generically, except where this would not be clinically appropriate or where there is no approved generic name – see the Nurse Prescribers' Formulary for District Nurses and Health Visitors, the Nurse Prescribers' Extended Formulary, the BNF and the Drug Tariff. Names of medicines and generic titles should not be abbreviated. Exceptions to this rule are for the prescribing of some dressings and appliances, and of compound or modified release medicines which have no approved non-proprietary name.
- directions, which should be in English and not abbreviated.
- where there is more than one item on a form, a line should be inserted between each item for clarity.
- unused space in the prescription area of the form should be blocked out with, for example, a diagonal line (to prevent subsequent fraudulent addition of extra items).
- prescribers' signature and date.
- on hospital prescriptions only: the nurse's / pharmacist's name printed or hand written in the box provided (to ensure that the dispensing pharmacist is aware who to contact if s/he has a query).

*Security and safe handling of prescription forms: good practice*

17. The security of prescription forms is the responsibility of both the employing organisation and the prescriber. It is advisable to hold only minimal stocks of the prescription forms. This reduces the number lost if there is a theft and also helps to ensure that up-to-date forms are used (they are normally revised annually).
18. The prescribers' employer should record the serial numbers of prescriptions received and subsequently issued to an individual prescriber, surgeries, clinics etc.
19. Local policy should be established on monitoring the use of prescription forms to deter the creation of fraudulent prescriptions.
20. The prescriber should also keep a record of the serial numbers of prescriptions issued to him or her. The first and last serial numbers of pads should be recorded. It is also good practice to record the number of the first remaining prescription form of an in-use pad at the end of

the working day. Such steps will help to identify any prescriptions that are either lost or stolen overnight.

21. Blank prescription forms must **NOT** be pre-signed, to reduce the risk of misuse should they fall into the wrong hands. In addition, prescription forms should only be produced when needed, and never left unattended. Prescription forms should not be left on a desk but placed in a locked drawer.
22. Best practice recommends that where possible, all unused forms should be returned to stock at the end of the session or day. Prescriptions are less likely to be stolen from (locked) secure stationery cupboards than from desks, bags or cars.

#### *Loss of prescription forms*

23. Astron (not the PPA) should be contacted about prescriptions ordered, but not received. The Counter Fraud and Security Management Services should only be notified if missing items are not found.
24. All prescribers working in primary care should report any loss or theft of prescription forms to the local counter-fraud specialist at the PCT as soon as possible after the theft/loss is confirmed. The prescriber should give details of the approximate number of prescriptions stolen, their identification numbers, and where and when they were stolen.
25. In consultation with regional or national counter-fraud operational teams where appropriate, the PCT/NHS local counter-fraud specialist at the trust should notify local pharmacists and decide upon any necessary action to minimise the abuse of the forms. The local counter-fraud specialist at the PCT/NHS trust should also inform the Compliance Unit at the NHS Counter Fraud and Security Management Services.
26. Following the reported loss of a prescription form, the PCT will normally tell the prescriber to write and sign all prescriptions in a particular colour (usually red) for a period of 2 months. The PCT will inform all pharmacies in their area and adjacent PCTs of the name and address of the prescriber concerned; the approximate number of prescriptions stolen and the

period within which the prescriber will write in a specific colour. This will normally be put in writing within 24 hours with the exception of weekends.

27. In the event of a loss or suspected theft, an NHS trust-employed prescriber should report this immediately to whoever issued the prescription forms (normally the hospital pharmacy). They will inform the local counter fraud specialist at the trust. The prescriber should give details of the number of prescriptions stolen, their serial numbers, and where and when they were stolen. Thereafter, hospital-based prescribers should follow local instructions following the loss or theft of prescription forms - this may include writing and signing all prescriptions in a particular colour (usually red) for a period of two months.

28. It is the responsibility of the employer to ensure that

- prescription pads are retrieved from nurse prescribers who leave their employment for whatever reason. NB. Prescription pads should be securely destroyed e.g. by shredding and putting into confidential waste. It is advisable to record first and last serial numbers of the pads destroyed. Failure to recover prescription forms may potentially incur a cost, as any item prescribed on forms after nurse prescribers have left employment would still be charged to their previous employer's budget.
- no further prescription pads are ordered for a prescriber who has left their employment or who has been suspended from prescribing duties, and
- to recover, record and securely destroy all unused prescription forms relating to that prescriber as soon as possible.

**NB All of the above requirements highlight the need for very clear channels of communication, particularly between GP practices/PMS pilots and PCTs.**

## ANNEX C

### Policy Statement - Record Keeping

All records created and maintained by health professionals should provide legible, accurate, current, comprehensive and concise information concerning the treatment of the condition and care of the patient/client and associated observations.

#### **Properly made and maintained records will:**

1. Be entered no later than 48 hours after the events to which they relate.
2. If the date of the entry does not coincide with the date of the contact with the patient then the date of the entry, actual time of visit and the date of the contact must be recorded.
3. Be written legibly and indelibly. Each entry must be signed with full signature and dated.
4. Be clear and unambiguous.
5. Be accurate in each entry as to date and time.
6. Alterations must be made by scoring out with a single line. **OTHER FORMS OF ERASURE OR DELETION – SUCH AS THE USE OF CORRECTION FLUID - MUST NEVER BE USED.** The correct entry should then be initialled, dated and timed.
7. Additions to existing entries must be individually dated, timed and signed.
8. All professionally held records must be stored in a secure manner in a locked file, drawer or cupboard.
9. Systems for storing and record keeping will exclude unauthorised access and breaches of confidentiality.

10. Meaningless phrases and offensive subjective statements, unrelated to patient care must not be used.
11. Abbreviations are only acceptable from the previously agreed list.

**In Addition:**

- A. The record of the nurse's prescription must be entered into the patient's records as close as possible to the time of writing the prescription.
- B. Where more than one record exists (e.g. a Trust nursing or Walk in Centre record and the hospital or GP record), information must be entered into each record as soon as possible.
- C. The record should clearly indicate the date, the name of the prescriber, the name of the item prescribed, the strength (if any), dose and the quantity prescribed. In hospitals the date and time of the last dose to be given may be used in place of a quantity to be dispensed. For preparations to be given or taken at a fixed dose or interval, the duration(s) of treatment can be recorded in place of prescribed quantity.

For medicinal preparations, (items to be ingested or inserted into the body), the dosage schedule and route of administration must be stated, e.g. Paracetamol oral suspension 5 ml every 4 hours, maximum of 20mls in 24 hours.

For topical medicinal preparations, the quantity to be applied and frequency of application must be included.

- D. In some circumstances, in the clinical judgement of the nurse prescriber, it may be necessary to advise the patient's doctor immediately of the medicine prescribed.

## ANNEX D

### **THE NURSING AND MIDWIFERY COUNCIL'S REQUIREMENTS FOR 'EXTENDED INDEPENDENT NURSE PRESCRIBING' AND 'SUPPLEMENTARY PRESCRIBING'.**

#### **Standard of programme**

- 1** *The standard of the programme should be no less than first degree level, such as to enable the registered nurse, midwife or health visitor, from parts 1, 3, 5, 8, 10, 11, 12, 13, 14 and 15, to acquire the competencies which are set out in section 8 of this paper.*
- 2** *A variety of assessment strategies should be employed to test knowledge and the application of theory to practice.*
- 3** *Assessment should focus upon the principles and practice of prescribing and, professional accountability and responsibility of the practitioners on the Council's register undertaking the role.*

#### **Kind of programme**

- 4** *The post-registration programme should be free-standing to meet the required competencies in practice.*
- 5** *Arrangements must be in place for teaching, supervision, support and assessment of the student prescriber in practice.*

#### **Content of the programme**

- 6** *Pre-programme preparation:*
  - 6.1** *each individual registered nurse's, midwife's or health visitor's previous education, training and experience will influence the amount of pre-programme preparation required before embarking on the prescribing programme at academic level 3*
  - 6.2** *institutions may offer assessment of prior (experiential) learning (AP(E)L) to accommodate those who are currently prescribing or, who may be able to demonstrate learning that is appropriate, to meet some of the competencies required of this standard.*
- 7** *Content of the programme:*
  - 7.1** *the content of the programme should reflect that prescribing is a competence based professional activity. The underpinning*

***knowledge requirements and competencies are outlined in Section 8 of this paper***

**7.2** ***the content should reflect the requirements of local commissioners across the four countries of the United Kingdom in addition to those specified in this standard.***

**8** ***The principal areas, knowledge and competencies required to underpin the practice of prescribing.***



Principal areas	Knowledge	Competence
<b>Principles</b>	<ul style="list-style-type: none"> <li>• Legislation that underpins prescribing</li>   <li>• Team working principles and practice</li>   <li>• Philosophy and psychology of prescribing</li> </ul>	<ul style="list-style-type: none"> <li>• Works within the legislative framework relevant to the area of practice and locality</li> <li>• Understands the principles behind supplementary prescribing and how they are applied to practice</li> <li>• Able to use the adverse reaction reporting mechanisms</li> <li>• Awareness of the impact of prescribing in the wider delivery of care.</li> <li>• Able to work and communicate as part of a multidisciplinary prescribing workforce</li> <li>• Reviews diagnosis and generates treatment options within the clinical treatment management plan</li>   <li>• Understand the complexity of the external demands and influences on prescribing</li> </ul>

<p><b>Practice</b></p>	<ul style="list-style-type: none"> <li>• Up to date clinical and pharmaceutical knowledge</li> <li>• Principles of drug dosage, side effects, reactions and interactions</li> <li>• Communication, consent and concordance</li> <li>• Relationship of public health requirements to prescribing</li> </ul>	<ul style="list-style-type: none"> <li>• Makes an accurate assessment and diagnosis and generates treatment options</li> <li>• Relevant to own area of expertise</li> <li>• Able to prescribe safely, appropriately and cost effectively</li> <li>• Understands how medicines are licensed, monitored</li> <li>• Able to work with patients and clients as partners in treatment</li> <li>• Proactively develops dynamic clinical management plans</li> <li>• Able to assess when to prescribe or make appropriate referral</li> <li>• Able to refer back to a medical practitioner when appropriate.</li> <li>• Aware of policies that have an impact on public health and influence prescribing practice</li> <li>• Able to articulate the boundaries of prescribing practice in relation to the duty of care to patients and society</li> </ul>
<p><b>Accountability</b></p>	<ul style="list-style-type: none"> <li>• The <i>Code of professional conduct</i>.</li> <li>• The lines of accountability at all levels for prescribing</li> <li>• Drug abuse and the potential for misuse</li> </ul>	<ul style="list-style-type: none"> <li>• Able to apply the principles of accountability to prescribing practice</li> <li>• Able to account for the cost and effects of prescribing practice</li> <li>• Regularly reviews evidence behind therapeutic strategies</li> <li>• Able to assess risk to the public of inappropriate use of prescribed substances</li> </ul>

	<ul style="list-style-type: none"> <li>• Requirements of record keeping</li> <li>• Lines of communication</li> </ul>	<ul style="list-style-type: none"> <li>• Understand where and how to access and use patient / client records</li> <li>• Able to write and maintain coherent records of prescribing practice</li> <li>• Able to communicate effectively with patients, clients and professional colleagues</li> </ul>
Responsibility	<ul style="list-style-type: none"> <li>• Leadership skills</li> <li>• Roles of other prescribers</li> <li>• Relationship of prescribers to pharmacists</li> <li>• Clinical governance requirements in prescribing practice</li> <li>• Audit trails to inform prescribing practice</li> </ul>	<ul style="list-style-type: none"> <li>• Able to advise and guide peers in the practice of prescribing</li> <li>• Able to articulate and understand the roles of other key stakeholders in prescribing practice</li> <li>• Understand the requirements of pharmacists in the prescribing and supply process</li> <li>• Link prescribing practice with evidence base, employer requirements and local formularies</li> <li>• Demonstrate ability to audit practice, undertake reflective practice and identify continuing professional development needs</li> </ul>

## A FRAMEWORK FOR TRAINING OF NURSE SUPPLEMENTARY PRESCRIBERS

Area of learning	Learning outcome	Related competency
General context of supplementary prescribing	<p><i>At the end of the module the student will be able to:</i></p> <p>Relate the concept of supplementary prescribing to systems and local arrangements</p> <p>Compare and contrast the concepts of supplementary and independent prescribing</p>	<p>Discusses the principles behind supplementary prescribing and how they are applied to practice</p> <p>Explains how local health service organisations work and interact</p>
Developing clinical management plans	<p><i>At the end of the module the student will be able to:</i></p> <p>Analyse the suitability of patients' situations for supplementary prescribing</p> <p>Incorporate patients' choice into the decision making process within supplementary prescribing</p> <p>Draft a Clinical Management Plan in conjunction with the Independent Prescriber</p>	<p>Ensures that the patient has consented to be managed by a prescribing partnership</p> <p>Maintains patient confidentiality</p> <p>Proactively negotiates with the Independent Prescriber to develop Clinical Management Plans</p> <p>With the Independent Prescriber, builds a complete medication history including complementary medicines, herbal remedies. OTCs</p> <p>Identifies the purpose, content and limits of individual clinical management plans</p> <p>Interacts with the patient in an appropriate setting</p> <p>Recognises the need for review or amendment of a Clinical Management Plan and takes appropriate action.</p> <p>Makes clinical decisions within the limits of the Clinical Management Plan in response to ongoing monitoring and the patient's condition</p>

<p>Prescribing in partnership</p>	<p><i>At the end of the module the student will be able to:</i></p> <p>Analyse the role of the supplementary prescriber in relation to the independent prescriber</p> <p>Demonstrate appropriate referral back to the independent prescriber or to another member of the wider care team</p> <p>Identifies the need to maintain the integrity of the prescribing partnership e.g. when addressing patient concerns</p> <p>Determine areas of poor practice in the supplementary prescribing partnership and initiate action to transform practice.</p> <p>Participate as an equal partner in the planned provision of patient care</p> <p>Identifies and uses managerial skills where appropriate</p>	<p>Maintains the integrity of the prescribing partnership</p> <p>Relates to the IP as an equal partner</p> <p>Regularly reviews evidence behind therapeutic strategies</p> <p>Prioritises and manages caseloads effectively</p> <p>Applies appropriate pharmacological and pharmacokinetic knowledge when implementing therapeutic strategies</p>
<p>Records and documentation</p>	<p><i>At the end of the module the student will be able to:</i></p> <p>Create comprehensive, accurate shared records to ensure safe practice in supplementary prescribing and rationalise the concept of multi-disciplinary access to records.</p>	<p>Accesses and interprets all relevant patient records to ensure full knowledge of the patient's management.</p> <p>Facilitates multidisciplinary access to patient's notes</p> <p>Makes appropriate use of information technology and takes account of local practices such as electronic prescribing when recording and documenting practice.</p>
<p>Knowledge of therapeutics</p>	<p><i>At the end of the module the student will be able to:</i></p> <p>Utilise a theoretical underpinning of therapeutics within a specialist area when selecting medication within supplementary prescribing</p>	<p>Discusses rationale for selection of certain medications</p> <p>Explains mode of action of selected medication to a patient and (in more detail) to a professional</p> <p>Accesses journal articles/texts, and other appropriate sources of</p>

	Utilise a variety of appropriate resources actively and effectively to inform and update knowledge related to therapeutics	information to demonstrate rationale for choice of medication  Makes contact with informed local personnel e.g. pharmacists
--	--	---

### Assessment strategy

Higher Education Institutions will need to propose an appropriate assessment strategy for this element of the supplementary prescribing course. This will need to ensure that practitioners achieve the relevant parts of the 'standards for extended independent nurse prescribing and supplementary prescribing' set by the Nursing and Midwifery Council, and available on their website at [www.nmc-uk.org](http://www.nmc-uk.org). The assessment strategy will also need to reflect the nature of delivery of this element, which may be integrated with the current course of preparation for 'Extended Formulary' (EF) nurse prescribing, or delivered as a discrete module for practitioners who have already successfully completed the EF nurse prescribing preparation.

Assessment of competence in practice will occur automatically because of the partnership nature of supplementary prescribing. This will not however need to be formally assessed before the practitioner can record their supplementary prescribing qualification with the Nursing and Midwifery Council.

### Length of programme

DH estimates that this element of the whole supplementary prescribing preparation is likely to be delivered over one to two days or equivalent. This is in addition to, rather than part of, the 25 day programme for Extended Formulary nurse prescribing preparation. DH has decided that the taught programme of the course combining Extended Formulary and Supplementary Nurse Prescribers will need to be at least 26 days long. Subject to this condition the detailed composition of the course can be decided by the HEI, but must lead to the achievement of the learning outcomes shown above, demonstrated by a robust assessment strategy.