

# NON-MEDICAL PRESCRIBING POLICY

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**The purpose of this policy is to give non-medical prescribers guidance and provide information and advice on good practice, including local process once qualified, training, accountability, record keeping, audit, security and handling and issues around prescribing.**

## **1. INTRODUCTION**

### **1.1 BACKGROUND TO NON-MEDICAL PRESCRIBING**

The original nurse prescribing scheme was based on the recommendations contained in the report of the advisory group on nurse prescribing 1989 (Crown Report). This advised ministers how introducing nurse prescribing might improve patient care in the community. Following the necessary legislation, nurse prescribing was piloted in 1994 and rolled out to nurses holding a district nurse or health visitor qualification from 1996 to 2001. After a three-month consultation with nursing, medical and pharmacy professional organisations in October 2000, ministers announced in May 2001 that nurse prescribing would be extended to more nurses and would include a wider range of medicines.

Following training, nurses prescribing under this extended scheme will be able to prescribe all general sales list and pharmacy medications currently prescribable by GP's under GPMS regulations, as well as a list of prescription only medications (POMs). Ministers also announced in May 2001 that supplementary prescribing by nurses and other health care professionals would be implemented which would allow these health professionals to prescribe for patients after they had had an initial assessment by a doctor and in accordance with a clinical management plan.

### **1.2 SCOPE**

This document sets out the policy and strategy for non-medical prescribing for NHS organisations within Surrey & Sussex Strategic Health Authority area. This document is a required policy for those who are employed by those organisations. For the purposes of this document, the term 'staff' is used as a convenience to refer to all those to whom this code of practice should apply. It is recommended as good practice for independent contractors and builds upon the work of all the professional bodies.

### **1.3 AIMS**

Surrey & Sussex SHA are committed in assisting organisations to enabling their workforce to work in autonomous and new ways. Prescribing will enable non- medical prescribers to provide the high clinical standards expected of them. For all our staff, the overall principles and practices of prescribing must be embedded within a sound and robust clinical governance framework, which is audited and evaluated on a regular basis. This policy provides non-medical prescribers with the legal constraints around prescribing, good practice issues and signposts to relevant documents and policies, which will assist them in maintaining and improving their prescribing competencies.

## **2. DEFINITIONS**

### **2.1 District Nurse and Health Visitor Nurse Prescribers (Mode 1)**

District Nurse (DN) and Health Visitor (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 XVIIB (i) of the Drug Tariff and the Nurse Prescribers' Formulary (NPF).

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. Following successful completion of this programme, the Nurse Prescriber will have his/her NMC registration entry annotated to show they are eligible to prescribe.

Following training, an independent nurse prescriber can only prescribe for a patient who she/he has personally assessed for care. In the absence of the original independent nurse prescriber, another independent nurse prescriber may issue a repeat prescription or order repeat doses following an assessment of need, and taking into account continuity of care. Accountability rests with the nurse who has prescribed the medication.

### **2.2 Extended Nurse Prescribing (EP)**

Nurses must be 1<sup>st</sup> level registered nurses or midwives who have the ability to study at level 3 and be able to access a prescribing budget prior to commencing training. After successful training the nurse or midwife will have his/her National Midwifery Council (NMC) registration annotated signifying they are eligible to prescribe from the Extended Formulary.

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), the NPF and in Part XVIIB (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. 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. In prescribing as in other areas of practice, nurses and midwives are bound by the NMC Code of Professional Conduct 2002 to act only within their competence. Individual nurse should therefore only prescribe from sections of the NPEF relevant to the areas of their clinical expertise.

**(See DH 2004, Extending independent nurse prescribing within the NHS in England)**

## 2.3 Supplementary Prescribing (SP)

The Department of Health (DH) defines this as 'A voluntary partnership between the responsible independent prescriber (a doctor or dentist) and a supplementary prescriber, to implement an agreed patient-specific clinical management plan with the patient's agreement' (DH 2003). Key features that should underpin supplementary prescribing emphasise: the importance of communication between the prescribing partners; the need for access to shared patient records; the patient is treated as a partner in their care and is involved at all stages in decision making, including whether part of their care is delivered via supplementary prescribing. Currently registered nurses and pharmacists can undertake supplementary prescribing training, and work will take place during 2004 to extend SP to physiotherapists, radiographers, podiatrists/chiropractors and optometrists.

There are no legal restrictions on the clinical conditions that may be treated although it is expected that supplementary prescribing would normally be used for the management of chronic conditions.

There is no specific formulary. Provided medicines are prescribable by a doctor or dentist and are in the Clinical Management Plan (CMP) which is a patient specific document that relates to an individual patient. Once it has been drawn up in conjunction with and agreed by the independent and supplementary prescribers, and the arrangement endorsed by the patient, the CMP enables the supplementary prescriber to manage the treatment of individual patient (including prescribing) within the identified parameters.

The patient needs to be reviewed by the independent prescriber after the interval stated in the CMP. This may be yearly, but in many cases will be less than this, and may occasionally, if the patient's condition is very stable be longer than this.

Items which may be prescribed by a supplementary prescriber are:

- All General Sales List (GSL) medicines, Pharmacy (P) medicines, appliances and devices prescribable by GPs.
- Foods and other borderline substances approved by the Advisory Committee on Borderline Substances (ACBS)
- All Prescription Only Medicines. (POMs)
- Medicines for use outside of their licensed indications (i.e. 'off label' prescribing), 'black triangle' drugs, and drugs marked 'less suitable for prescribing' in the BNF.
- Unlicensed drugs provided they are part of a clinical trial that has a clinical trial certificate or exemption.

**[NB Subject to Parliamentary approval to changes to the Home Office's Misuse of Drugs Regulations and to related amendments to NHS Regulations, nurses and pharmacists will be able to prescribe controlled drugs under a supplementary prescribing arrangement later in 2004]**

## 2.4 All Non-Medical Prescribers - Limitations

Non-medical prescribers must ensure that the patient is aware of the scope and limits of their prescribing and how the patient can obtain other items necessary for their care

## **2.5 Repeat Prescriptions**

- Non-medical prescribers may prescribe a maximum of one calendar month's treatment on each prescription
- Patients requiring long term treatments should be reassessed either after six repeat prescriptions or six months.

## **2.6 Differences between Non Medical Prescribing and Patient Group Directions (PGD)**

An Independent Nurse Prescriber is accountable and responsible for the assessment, diagnosis and prescribing decision made within the remit of the Nurse Prescribing Formulary for each individual patient/client seen.

A Patient Group Direction (PGD) is defined as a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. It is not a form of prescribing and although there is no specific training that a health care professional must undertake before supplying medicines in this way, most organisations are now ensuring that those involved must attend/access in-house training/information. The healthcare professional must be conversant with each PGD before undertaking administration.

(See DH, *Mechanism of Nurse and Pharmacy Prescribing and Supply of Medicines* at [www.dh.gov.uk](http://www.dh.gov.uk) following the route Homepage>Policy and Guidance>Medicines, Pharmacy and Industry>Prescriptions and Prescribing>Nurse Prescribing)

PGDs are developed in situations where it may not be feasible to have separate prescriptions written for each individual client, such as with childhood immunisation programmes, and where it is possible to follow clearly defined guidelines to assist the assessment and diagnosis of a condition and where the availability to dispense treatment enhances care provision – such as Walk in Centres, Minor Treatment Units, Schools, PMS sites and community pharmacies.

**(See Appendix 1 To PGD or Not to PGD – Beth Taylor 2004)**

## **3 TRAINING**

### **3.1 Prescribing training**

The training for supplementary prescribing (SP) for nurses is the same as for extended prescribing (EP), with the addition of a short module covering the context of SP.

Pharmacists only train as SPs.

EP/SP prescribing training consists of 25/27 taught days at degree level over a three or six month period, followed by additional self directed learning and at least 12 days of learning in practice with an appropriately trained medical supervisor (e.g. GP). All new DNs and HVs now undertake mode1 prescribing training as part of their Specialist Practitioner Degree.

### **3.2 Application Process for Non-Medical Prescribing**

Prior to application for non-medical prescribing, the service area needs to do an option appraisal to ascertain the need for non-medical prescribing.

**(See Appendix 2 An Option Appraisal of Prescribing)**

For healthcare professionals wishing to undertake EP/SP prescribing, the Surrey & Sussex SHA has an application process which is available from the organisation's Non-Medical Prescribing Lead.

## **4 PROCESS ONCE QUALIFIED**

There is an administration process in place for nurse prescribers, for both newly qualified prescribers and new nurse prescriber employees.

**(See Appendix 3 include own Operational Flow Chart).**

## **5 PRESCRIBING**

### **5.1 Principles of prescribing**

Prescribers should follow the seven principles of prescribing:

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

**(National Prescribing Centre 1999)**

### **5.2 Good Prescribing Practice**

#### **Writing the script**

- Non-medical prescribers FP10 pre-printed prescription pad is lilac in colour and issued bearing the non-medical prescribers own name and code.
- Electronically generated prescription forms will be available in the very near future and will be the same green FP10 that the GP uses, the non-medical prescribers details will automatically be printed onto the form when they are logged on to the computer, in the same way as the GP.
- Inpatient drug charts should be used for those working in acute Trusts.
- Non-medical prescribers in an outpatient situation issuing FP10HNC (previously FP10HP) should ensure they identify their speciality and capacity of non-medical prescriber, using the locally agreed codes.
- Under no circumstances should blank prescription forms be pre-signed before use.
- The non-medical prescriber must ensure that all details on the pad are:
  - Clear
  - Legible
  - Written in black ink (indelible)
  - Using generic name of drug where possible

**(See Appendix 4 How to complete the prescription form for details)**

All National Guidelines e.g. NICE, NSFs and local prescribing guidelines/policies should be adhered to. Prescribers need to keep abreast of changes.

### **Adverse Drug Reactions**

Adverse Drug Reactions need to be reported by the Yellow Card Scheme; hard copies of the form can be found at the back of the BNF; electronic copies can be found at [www.mca.gov.uk/yellowcard](http://www.mca.gov.uk/yellowcard). A photocopy needs to be entered into patient's notes and the GP informed.

Non-medical prescribers must also follow local policy with regard to incident reporting.

### **5.3 Monitoring of Prescribing**

The safety, effectiveness, appropriateness and acceptability of prescribing must be evaluated by the independent prescriber and the employer. Monitoring of all non-medical prescribing should be undertaken by the prescribing team where possible. Quarterly reports will be discussed at the Non-Medical Group and the Prescribing and Medicines Management Committee meetings.

### **5.4 Unregistered Patients – Homeless/Refugees/Travelling Families & Asylum seekers**

Non-medical prescribers can prescribe for patients/clients who are not registered with a GP practice at all, such as patients/clients within homeless projects, transient residents, for example refugees and asylum seekers or those recently moved into the area.

The Prescribing team will set up a designated code 'non-registered' to be used in these situations, in the short term. Prescribing will be closely monitored to ensure that this account is used **ONLY** for unregistered patients and clients. All efforts must be taken to facilitate the registration of the patient/client with a local general practice.

### **5.5 Out of Boundary – other PCTs**

Non-medical prescribers employed by a PCT may only issue prescriptions for the patients of GP practices within that PCT. In addition, if they are involved in providing services through a Community Nurse Prescribing Contract, they can issue prescriptions for patients of GP practices outside that PCT covered by the contract and for which a prescribing budget has been agreed.

Non-medical prescribers can prescribe for patients/clients who are registered with GPs outside their employing PCT provided these GPs' prescribing codes have been made available to the prescribers by the respective PCTs. Each non-medical prescriber should liaise with the GP practices she/he works with from outside their employing PCT to ensure that they have the correct GP code. **Non-medical prescribers should not use a GP code other than the code for the GP that the patient is registered with.**

### **5.6 Private GPs**

It is **NOT** possible to provide NHS prescriptions for patients/clients who are only registered with a private GP.



## 5.7 Drug and Appliance Alerts

In an event of a drug or appliance alert being received, the non-medical prescriber is responsible for taking immediate appropriate action.

## 5.8 BNFs, NPFs and Drug Tariffs

Supplementary prescribers and nurses able to prescribe from the Extended Formulary receive a copy of the BNF every six months funded by the DH. The Nurse Prescribers' Formulary (NPF) for DNs, HVs and other nurse prescribers is supplied biennially via the Non-Medical Prescribing lead. Prescribers will be able to access the Drug Tariff through the Prescription Pricing Authority (PPA) websites [www.ppa.nhs.uk](http://www.ppa.nhs.uk) or [www.ppa.org.uk](http://www.ppa.org.uk)

(Appendix 5 Eligibility BNF/NPF)

## 5.9 Dispensing Of Prescriptions

Any prescription written must be dispensed before travel outside the UK.

## 5.10 Direction of Prescriptions

- Prescriptions should be dispensed at the patient's pharmacy of choice.
- Non-medical prescribers **must not direct prescriptions** to specific pharmacies

## 5.11 Prescribing For Self, Family and Friends

All prescribers 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) all non-medical prescribers **should avoid** prescribing for themselves or close family members, as judgement may be impaired and important clinical examination may be impossible.

## 6. ACCOUNTABILITY

Each non-medical prescriber is individually and professionally accountable for their practice and is at all times expected to work within the standards and code of professional conduct as set out by their own Regulatory bodies; for nursing this is the Nursing and Midwifery Council (NMC), for Pharmacists it is the Royal Pharmaceutical Society of Great Britain (RPSGB), as well as Policies and Guidelines ratified by their employing organisation.

## 7. RECORD KEEPING

It is recommended that to ensure good communication within primary and secondary healthcare, the non-medical prescriber should enter legibly the following details into the records:

- the date of prescribing
- the name, dosage, route of administration and quantity of item prescribed
- the name of the prescriber and signature.
- If the date of the entry does not coincide with the date of the contact with the patient then the date of entry, actual time of visit and the date of the contact must be recorded.
- Alterations must be made by scoring out with a single line. Other forms of erasure must never be used.

Information should be documented in the following places;

1. The client/patient held records at the time of issuing the prescription.
2. The clinic held records within 24 hours of the prescription being generated.
3. The surgery held records – computer and/or manual – within two working days of a prescription being generated, using Trust proforma. This can be done either personally or by fax to the named person at the surgery.

If the independent nurse prescriber is covering for a prescribing colleague and writes a prescription for a patient from another practice, this information must also be sent to the DN or HV attached to that practice.

Supplementary prescribers must ensure that there is a copy of the current Clinical Management Plan filed in the patient's notes, and that this is updated as necessary.

Any adverse incidents **MUST** be recorded via an adverse incident form. (See section 5.2)

## 8. AUDIT

Audits are to be maintained in line with recommendations from the employing NHS organisation. Each non-medical prescriber is responsible for his/her individual practice, and must carry out regular reviews of his/her prescribing practice. Assistance with identifying audit methodologies and interpreting findings should be available through the employing organisations' normal clinical governance mechanisms. Individual non-medical prescriber PACT data is only available on request to the PPA.

## 9. SECURITY AND SAFE HANDLING

### 9.1 Controlled Stationery - Prescription Pads

- Controlled stationery is any stationery, which, in the wrong hands, could be used to obtain medicines and/or medical items fraudulently. Prescriptions are considered controlled stationery.
- The prescription pad is the property of the employing organisation.
- It is the responsibility of the individual non-medical prescriber to ensure the security of the prescription pad at all times.

- The prescriptions for non-medical prescribers (FP10P) have the designation of the prescriber printed on the top as follows:  
DISTRICT NURSE/HEALTH VISITOR PRESCRIBER PN for practice nurses  
DISTRICT NURSE/HEALTH VISITOR PRESCRIBER CN for community nurses  
EXTENDED FORMULARY NURSE PRESCRIBER being phased out – soon to be only; EFNP/NURSE SUPPLEMENTARY PRESCRIBER  
PHARMACIST SUPPLEMENTARY PRESCRIBER
- **Under no circumstances should blank prescription forms be signed before use. The prescription form should only be produced when needed.**
- Prescription pads must not be left unattended on the desk or work surface, but should be locked away securely and access should be restricted to individual prescribers
- When the non-medical prescriber is travelling between work base and patient/client or other clinic, the prescription pad must not be visible. It must be locked in a secure place (such as a car boot) or carried out of view on the person.
- The non-medical prescriber should not carry large numbers of prescription forms with him/her. He/she should only carry enough to cover the needs of that day's anticipated workload.
- The non-medical prescriber can only write prescriptions on a prescription form bearing their name.
- Non-medical prescribers cannot issue prescriptions for patients/clients not on their caseload, unless that non-medical prescriber has made an assessment / reassessment of the need for a prescription.
- Prescription pads must be returned to the Trust before the last day of employment.
- Prescription pads are delivered to the non-medical prescriber's stated delivery address. Each delivery address needs to ensure that there is:
  - a secure system in place for the receiving and temporary storage of prescription pads
  - a designated person responsible for receiving and signing for the prescription pads and recording the serial numbers of the prescriptions received which will be subsequently issued to the individual prescriber
  - a secure lockable drawer or cupboard for the temporary storage of prescription pads
  - a receipt book for signing for receipt of the prescription pads when collected by the non-medical prescriber

## 9.2 Loss or Suspected theft of Prescription Pads

The non-medical prescriber MUST keep a record of the serial numbers of the 1<sup>st</sup> & last one on receipt of a new prescription pad. It is advisable that the prescriber must be aware of all prescriptions used / written so in the event of a pad been lost or stolen the number remaining can be estimated.

### **9.3 Non-Medical Prescriber – Responsibility**

It is the responsibility of the individual non-medical prescriber to report the loss or suspected theft of prescription forms/pads immediately to:

- their line manager
- the Non-medical Prescribing Lead

If the incident occurs out of hours, it must be reported on the next working day.

**A Trust Incident reporting form MUST BE COMPLETED, in accordance with the Trust Risk Management Policy.**

The following steps are to be taken:

### **9.4 Organisational Guidance**

Insert organisational guidance here.

## **10. CONTINUING PROFESSIONAL DEVELOPMENT (CPD) FOR NMP**

All healthcare professionals including non-medical prescribers have a statutory responsibility to maintain their CPD. This is in line with the National Prescribing Centre competencies framework. During April 2004-March 2005 there has been an identified budget for organisations within the Surrey & Sussex SHA to bid for funding specifically for NMP CPD.

## **11. LOCAL FORMULARIES**

### **11.1 Trust Formularies**

It is expected that non-medical prescribers follow their locally agreed Trust formularies and guidelines.

### **11.2 GP Practice Formularies**

Individual GP practices may have prescribing formularies/policies in respect to the prescribing of items, which are available from each respective practice. Each Non-medical Prescriber should liaise with the GP practices she/he works with to familiarise themselves with any GP practice formularies/policies. Where appropriate the NMP should practise within these formularies.

### **11.3 Relationship with the Pharmaceutical Industry**

The advertising and promotion of medicines is strictly regulated under the Medicines (Advertising) Regulations 1994, and the choice of which medical products are used is based on clinical suitability and value for money alone. The Surrey & Sussex SHA is aware that pharmaceutical representatives approach healthcare professionals. Healthcare professionals must adhere to the standards of their own professional body and their employing organisational Policy for Working with the Pharmaceutical Industry.

#### 11.4 Gifts and Benefits

As part of the promotion of a medicine(s), suppliers may provide inexpensive gifts and benefits for eg pens, diaries, mouse mats etc. Personal gifts are prohibited, and it is an offence to solicit or accept a prohibited gift or inducement.

#### 12. SUPPORTING POLICIES

Organisations can insert these here.

#### 13. REVIEW OF THE POLICY

This will be an evolving policy as the standards and practice covered continue to change. Where appropriate it will be supplemented by additional guidance from the Department of Health and other relevant bodies. It is anticipated that the employing organisation will formally review the policy in the light of any major changes to the legal framework.

#### 14. Local Contacts

**(insert relevant organisational information below)**

Title	Contact Name	Telephone No	Fax No
Non-Medical Prescribing Lead			
Non-Medical Prescribing Facilitator - Surrey & Sussex Strategic Health Authority	Fiona Peniston-Bird <a href="mailto:fiona.peniston-bird@sysxha.nhs.uk">fiona.peniston-bird@sysxha.nhs.uk</a>	07818 098 438	01293 847060
Lead Pharmacist			
Prescribing Team			
Medicines information			

### **On-line information sources**

1. *Medical & Healthcare Products Regulatory Authority* - produce a quarterly bulletin which contains advice and information on drug safety issues. *Current Problems in Pharmacovigilance* can be found on [www.mhra.gov.uk](http://www.mhra.gov.uk)
2. Department of Health website – wide range of information and links to other sites [www.DH.gov.uk/nurseprescribing](http://www.DH.gov.uk/nurseprescribing)  
[www.DH.gov.uk/supplementaryprescribing](http://www.DH.gov.uk/supplementaryprescribing)
3. Nurse Prescriber – free website supported by the RCN that provides educational and practice information to nurse prescribers  
[www.nurse-prescriber.co.uk](http://www.nurse-prescriber.co.uk)
4. National Prescribing Centre provides information for prescribers on developing competency and practice [www.npc.co.uk/nurse\\_pres](http://www.npc.co.uk/nurse_pres)
5. The PRODIGY website provides advice on clinical management and prescribing guidelines [www.progidy.ns.uk/nurse](http://www.progidy.ns.uk/nurse)
6. The Prescription Pricing Authority [www.ppa.nhs.uk](http://www.ppa.nhs.uk) or [www.ppa.org.uk](http://www.ppa.org.uk) for the drug tariff.
7. The BNF at [www.bnf.org](http://www.bnf.org) .
8. Drug Info Zone email daily updates relating to all aspects of clinical management and prescribing guidelines [www.druginfozone.nhs.uk](http://www.druginfozone.nhs.uk)

### **15 REFERENCES/FURTHER READING**

1. DH (2003) *Supplementary prescribing by nurses and pharmacists within the NHS in England. A guide for implementation.* 2003
2. National Prescribing Centre 1999, *Seven Principles of good prescribing. A stepwise approach.* Prescribing Nurse Bulletin Volume 1 (1)
3. National Prescribing Centre (2003) *PCT Responsibilities around prescribing and medicines management – a scoping and support guide.* Liverpool.
4. DH (2<sup>nd</sup> Edition February 2004) *Extending Independent Nurse Prescribing within the NHS in England. A guide for implementation*

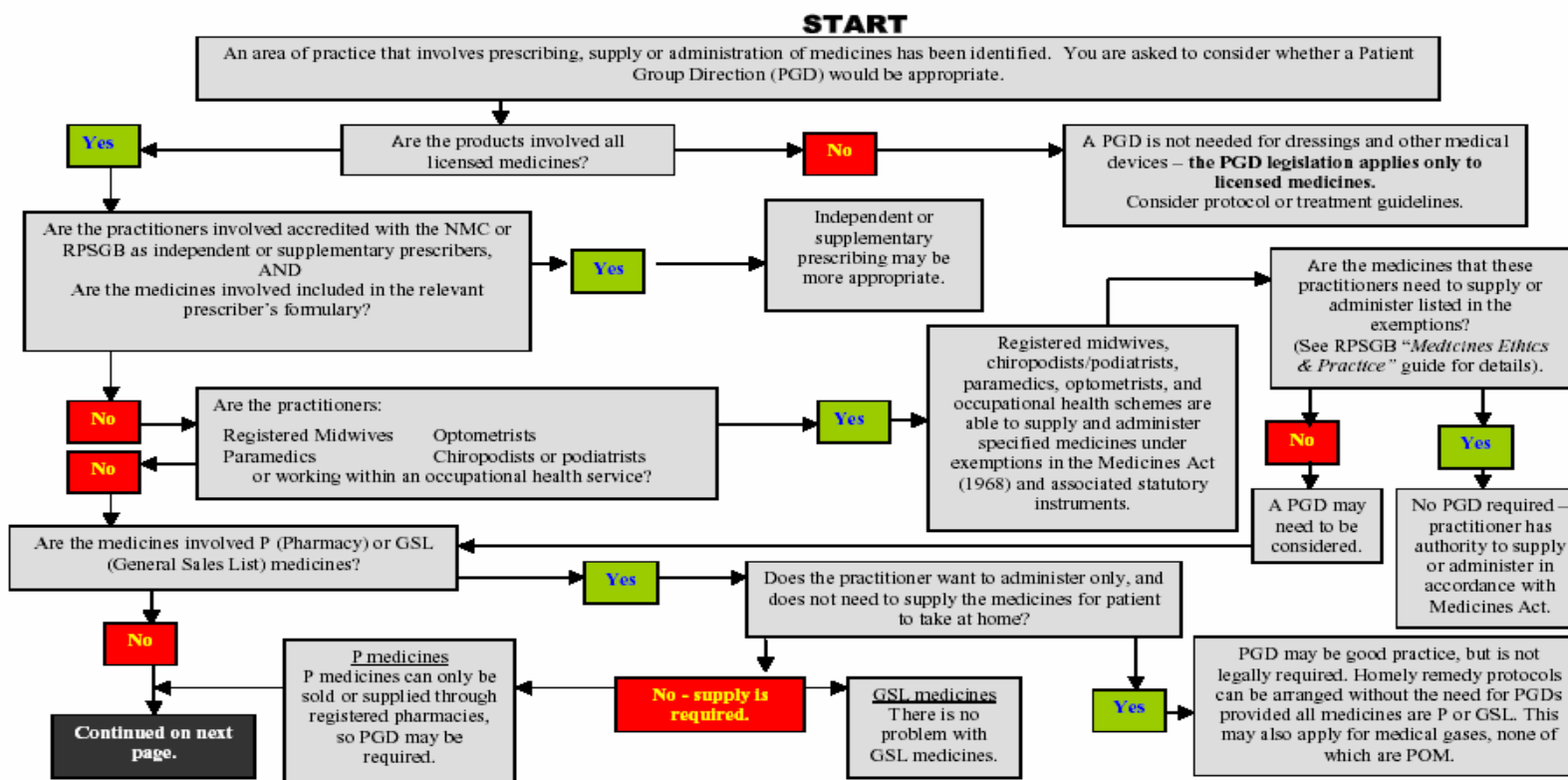
## Appendix 1

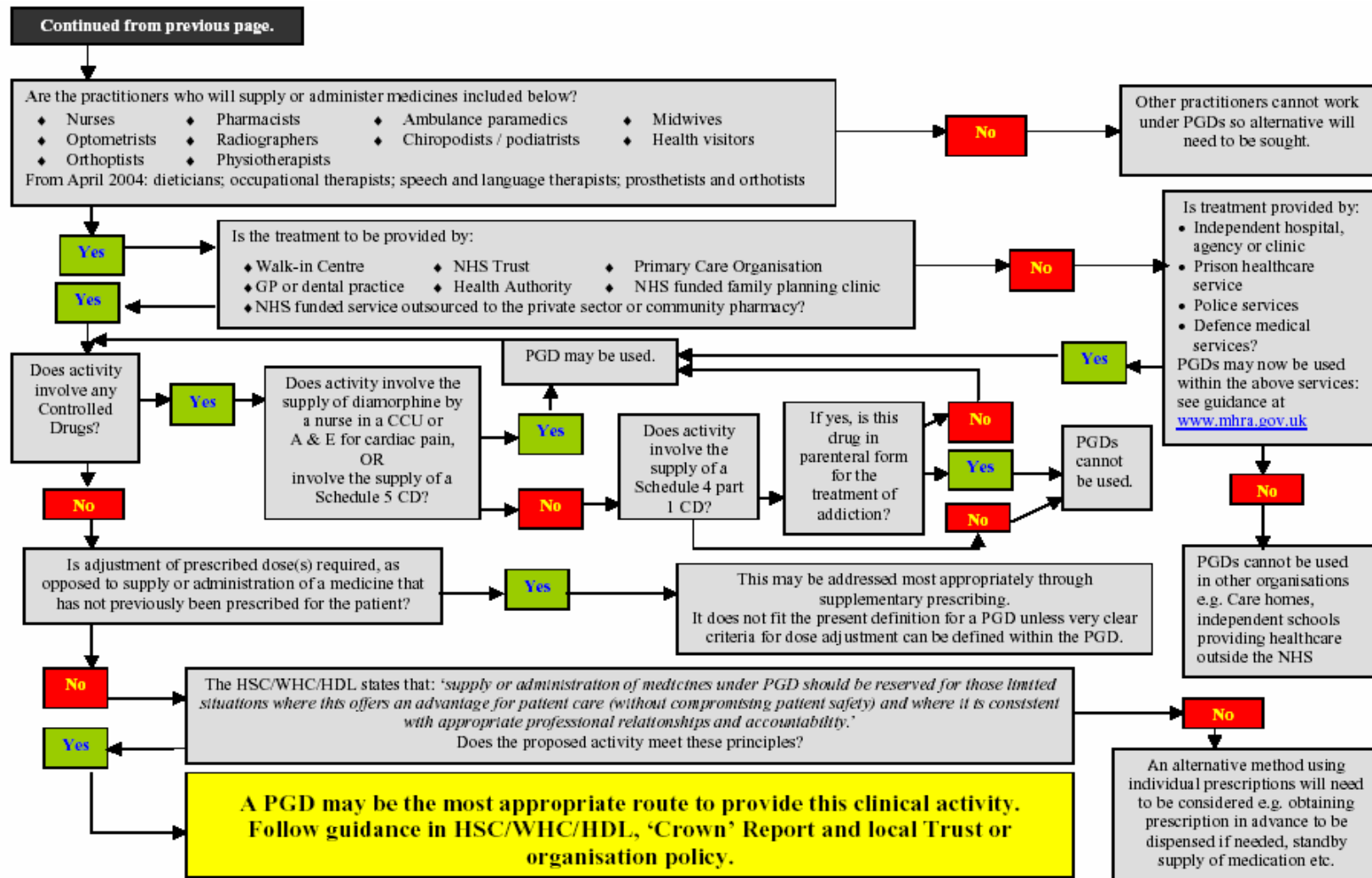
### TO PGD OR NOT TO PGD? – That is the question.

(A guide to choosing the best option for individual situations)

This guide has been prepared in response to the many queries that are now being raised both locally and nationally about the implementation of HSC 2000/026 (in England), WHC (2000) 116 in Wales, HDL (2001) 7 in Scotland, on Patient Group Directions. The co-incidental introduction of independent and supplementary prescribing has confused many practitioners, and there is a danger that inconsistencies may develop as the implementation of both initiatives continues.

Practitioners and their managers who wish to formalise or set up new systems for prescribing, or alternatively the supply or administration of medicines, are faced with a range of different methods and need to select the most appropriate route in each case. The diagram below takes the practitioner through a logical process that aims to assist decision-making. **The majority of clinical care should still be provided on an individual, patient-specific basis**







## Surrey & Sussex Strategic Health Authority

### Appendix 2

Formatted

#### **An option appraisal of present and future methods of prescribing, administering or supplying medicines by nurses**

This guide is intended as a tool to illustrate the full range of options open to health services in the future, in addition to existing non-medical prescribing and patient group directions, when both independent and supplementary prescribing are fully implemented. It is intended to help service decide whether they need to consider any new options, and to prepare a 'business case' based on the potential benefits for patients.

**It is important to retain this patient focus, as it is this that is guiding the next phase of the implementation of non-medical prescribing.**

##### **Describe the service you are currently providing to patients**

Look at this service in its entirety – should any changes be considered, e.g. an alternative method of supply or prescribing medicines to better meet patients need?

##### **Are there new or additional services you would like to include when non-medical prescribing is extended?**

#### **Consider the following points in relation to your service:**

- How would any change to current prescribing or supply arrangements improve the services you offer your patients?
- Are existing independent prescribers able to prescribe for all patients without unnecessary delays/time wasting?
- Will an independent prescriber need to make the diagnosis and decide on a treatment plan before you can treat the patient?
- Consider the conditions you aim to treat, and the competencies of staff working in your service: does the proposed expanded NPF meet your requirements for prescribing?
- Are any controlled drugs involved?
- Do you need to prescribe or administer only, or do you also need to prescribe medicines for patients to take home?
- Do the conditions and treatments your service provides easily fit pre-determined criteria?
- What links/referral routes do you have with other providers and prescribers
- Would patient care be compromised in any way by any proposed changes, i.e. is it safe?
- Are the medicines involved well established, i.e. not black triangle?

The main range of options available to nurses now and in the future are shown on following page. Combinations of these options are also possible, e.g. a family planning nurse might in the future prescribe independently for some patients, and use a PGD for others

Option A Independent prescribing by a nurse	Option B Supplementary prescribing by a nurse, pharmacist or allied health professional (when introduced)	Option C Patient Group directions	Option D Referral to community pharmacy (for over the counter medicines only)	Option E Referral to another independent prescriber
<b>Possible advantages for service and patients</b>				
<ul style="list-style-type: none"> <li>• More responsive and complete service offered – no delays</li> <li>• Wider range of products available than may currently be held as stock (subject to NPF)</li> <li>• May reduce waste</li> <li>• Enhances job satisfaction for staff involved</li> </ul>	<ul style="list-style-type: none"> <li>• Wider range of products than Option A</li> <li>• Good fit for clinical conditions requiring regular monitoring</li> <li>• Encourages more consistent clinical practice than in A</li> <li>• May be preferred option for dose adjustment in chronic illness e.g. diabetes, asthma</li> <li>• Allows review of prescribing by a second practitioner</li> </ul>	<ul style="list-style-type: none"> <li>• Promotes consistent clinical practice</li> <li>• Can offer 'one stop' service</li> <li>• Control over presentation and labelling of products supplied</li> <li>• Detailed guidance can be included in PGD</li> <li>• Fewer restrictions re products</li> <li>• Better control of budget than in A or B</li> </ul>	<ul style="list-style-type: none"> <li>• Full range of OTC products available</li> <li>• Access to advice from pharmacist</li> <li>• No funding or administrative system needed</li> </ul>	<ul style="list-style-type: none"> <li>• May be safest for patients with multiple complaints</li> <li>• May be safest if there are concerns about interactions with existing medication</li> </ul>
<b>Possible disadvantages for service and patients</b>				
<ul style="list-style-type: none"> <li>• Delay before audit data available</li> <li>• Prescribing practices may not be consistent</li> <li>• Prescribing Responsibility cannot be shared</li> <li>• Limited to accredited individuals</li> <li>• Less control over budget</li> </ul>	<ul style="list-style-type: none"> <li>• Diagnosis and clinical management plan must be agreed with independent prescriber</li> <li>• Relies on good communication between independent and supplementary prescriber</li> <li>• Patient specific</li> <li>• Split accountability for prescribing decisions</li> <li>• Delay before audit data available</li> <li>• Will require access to common patient records</li> </ul>	<ul style="list-style-type: none"> <li>• Additional workload in preparing and maintaining PGD, stockholding, and collecting prescription charges</li> <li>• Audit more difficult (but no delay)</li> <li>• Endorsement of protocol by doctor and pharmacist required</li> <li>• Little scope for individual clinical judgement</li> <li>• Clinical conditions must be pre-defined or within agreed scope of practice</li> <li>• Limited to locally determined accredited individuals who must be suitably trained</li> <li>• May by-pass pharmacist - no second person check etc</li> </ul>	<ul style="list-style-type: none"> <li>• Patient pays regardless of exemption status</li> </ul> <p>No data for audit</p>	<ul style="list-style-type: none"> <li>• May lead to delay in obtaining treatment</li> <li>• Must ensure that independent prescriber chosen has access to all relevant patient information</li> </ul>

The five main options for the future, based on experience to date in community practice

Beth Taylor, Specialist Principal Pharmacist, Community Care, London/South

# Surrey & Sussex Strategic Health Authority

## Appendix 4 How to complete the prescription form

Detailed advice on prescription writing is contained in the NPF & BNF

### 1. Details required on the front of the prescription form are:

- Patient's title
- Patients surname & first name
- Age and date of birth (*It is a legal requirement to write the patient's age on the prescription when prescribing Prescription Only Medicines (POMs) for a child under twelve years of age*)
- Full address including postcode
- The name of the prescribed item (plus size & strength if any)
- Form (e.g. cream, oral)
- Dosage (with maximum dose)
- Frequency and quantity
- The prescriber's signature
- The prescriber's telephone number
- Date script issued
- GP code

### 2. The prescription should contain:

- The name of the prescribed item
- Formulation
- Strength (if any)
- Dosage and frequency, in the case of "as required" a minimum dose interval should be specified.
- Quantity to be prescribed

### 3. Quantity

The quantity prescribed should be

- appropriate to the patient's needs, bearing in mind the need to avoid waste.
- 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). Terms such as '1 pack' or '1 OP' should not be used. Alternatively, for preparations to be given for a fixed dose and interval, the duration(s) of treatment can be given in place of quantity to be dispensed.

n.b. some preparations are only available in patient packs and the quantity contained in the packs should be prescribed, provided this is clinically and economically appropriate.

### 4. The names of medicines should be written clearly

Prescribers are recommended to prescribe generically, except where this would not be clinically appropriate or where there is no approved generic name (refer to NPF, 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.

### 5. Directions should be in English and not abbreviated.

### 6. Where there is more than one item on a form, a line should be inserted between each item for clarity.

### 7. Unused space in the prescription area of the form should be blocked out with, eg a diagonal line (*to prevent subsequent fraudulent addition of extra items*)

### 8. Prescriber's signature, telephone number and date

The telephone no. may be necessary for the dispensing pharmacist to contact the prescriber in the event of a query regarding the prescription.

**PCT employed nurses and non-medical prescribers should include the GP practice code**

Appendix 5

## Non-Medical Prescribers Eligibility for BNF's and NPF's

### **Extended Formulary Nurse Prescribers.**

Nurses qualified to prescribe from the extended formulary should receive a BNF during training and then twice yearly thereafter. (Extended Formulary Independent Nurse Prescribing within the NHS in England – A guide for implementation. DOH, March 2002, page 4, paragraph 13) Available on the DoH Nurse Prescribing website: [www.doh.gov/nurseprescribing](http://www.doh.gov/nurseprescribing) .

### **Supplementary Prescribers.**

Supplementary Nurse Prescribers (SNP's) when qualified will also be trained as EFNPs. They should receive a BNF during training and then twice yearly thereafter.

### **Pharmacist Supplementary Prescribers.**

Pharmacists currently receive BNF's six monthly.

### **District Nurses /Health Visitors.**

All Nurse Prescribers including qualified District Nurse and Health Visitor Nurse Prescribers will receive an updated copy of the NPF every two years, and on this occasion will be in place of a BNF.

### **Nurses who are not Prescribers.**

Any nurse who has not trained as a prescriber (either EFNP or DN/HV) is not entitled to a centrally provided BNF or NPF.

**Ordering and Distribution of BNF/ NPF.** The University will supply the extended formulary nurse prescriber (EFNP) with the initial NPF/ BNF. Subsequent copies of the BNF will be provided through a single contact point in each Hospital Trust or Primary Care Trust that the EFNP is employed.

The Non-Medical prescribing lead or administrator for each PCT / Acute Trust will identify nurse prescribers entitled to a centrally funded BNF/ NPF.

The PCT/ NHS trust Lead will provide the Non-Medical Prescribing Facilitator at Surrey and Sussex Strategic Health Authority with the Numbers of BNF/ NPF required for the forthcoming period, together with a collated list of all DN/ HV, EFNP and SNP to **include their full name, work contact address & telephone number, job title, NMC Pin Number and mode of prescriber**. This information is required twice yearly, by mid-January and mid- July from the PCT/ NHS Trust leads.

The Non-Medical Prescribing Facilitator (Surrey & Sussex SHA) will maintain an updated list of PCT/ Acute NHS Trust non-medical prescribing

leads. Twice yearly, BNF/ NPF numbers will be collated and forwarded to Kathy Mann at DOH, together with updated contact list in mid-February and mid August each year.

**Buying Extra Copies of BNF.**

NHS employers who wish to purchase copies of the BNF for staff who do not qualify for those centrally provided, should contact Kathy Mann. A form will be provided that will enable purchase of BNF's at a reduced price (currently £10.15 per copy for a minimum order of 10 copies). A separate order form will be needed for each edition. Orders of less than 10 copies will need to be purchased direct from the Pharmaceutical Press (phone 01491 829272) or from a good bookshop.

**University Order of BNFs/ NPFs for Nurse Prescribing Training.**

Universities should order BNF's for EFNP/ SNP Training or NPF's for District Nurse/ Health Visitor prescriber training by e-mailing David Price (e-mail: [david.price@doh.gov.uk](mailto:david.price@doh.gov.uk)). Please allow at least four weeks for the books to arrive.

**Drug Tariffs.**

All prescribers are entitled to a drug tariff once every six months. It is the PPA who supplies drug tariffs through their distributors. Kathy Mann at the DOH forwards the contact details for prescribers to the PPA.

**Contact Details:**

Fiona Peniston-Bird  
Non-Medical Prescribing Facilitator for Surrey & Sussex.  
South East (South Coast)  
Pharmacy Education & Training  
2<sup>nd</sup> Floor, York House,  
18-20 Massetts Road,  
Horley  
Surrey  
RH6 7DE  
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