

**Supplementary Prescribing by  
Nurses within  
NHSScotland**

**A Guide for Implementation**

Scottish Executive Health Department



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## HOW TO USE THE GUIDE

This guide has been prepared for:

- NHS Organisations
- Personal Medical Services Pilots
- General Practitioners
- Pharmacists
- Higher Educational Institutions providing nurse education

Other groups who will be interested in the guide, and who have therefore been sent a copy, include:

- Nurse prescribing Leads
- Existing Nurse Prescribers
- Community Services Pharmacists employed by, or contracted to, NHS organisations
- Patient Groups

It will be for NHS Organisations to consider, in light of local priorities, which nurses in their area should undertake preparation for supplementary prescribing. This guide has been prepared to assist them. Copies of all or part of the Guide may be reproduced at local level as required.

It might also be of interest to the Prison Healthcare Service, the Defence Medical Services and the independent healthcare sector.

It can be found on the Scottish Executive Health Department's website: [www.show.scot.nhs.uk/sehd/nurseprescribing](http://www.show.scot.nhs.uk/sehd/nurseprescribing). The website contains other detailed information on the prescribing and supply of medicines by nurses and will be kept up to date on future developments.

# INTRODUCTION

1. This guide sets out the administrative and procedural steps needed to enable registered nurses and registered midwives to act as supplementary prescribers. It also provides advice on good practice for supplementary prescribers and their independent prescriber partner (doctor or dentist). **[NB Where the term “nurse” is used in this document it includes Registered Midwives]**

## *Scope of this guidance and effect of devolution*

2. This guide sets out the steps required to implement supplementary prescribing in Scotland. Medicines legislation permits the introduction of supplementary prescribing across the UK, and Ministers in Scotland have decided that supplementary prescribing will be implemented. Further guidance will issue in due course for supplementary pharmacist prescribers.

## BACKGROUND

### *General*

3. Supplementary prescribing has its basis in the recommendations of the final report of the Review of Prescribing, Supply and Administration of Medicines (1999), which recommended that two types of prescriber should be recognised:
  - the **independent prescriber** who would be responsible for the assessment of patients with undiagnosed conditions and for decisions about the clinical management required, including prescribing;
  - the **dependent prescriber** who would be responsible for the continuing care of patients who have been clinically assessed by an independent prescriber. This continuing care might include prescribing, which would usually be informed by clinical guidelines and be consistent with individual treatment plans, or continuing established treatments by issuing repeat prescriptions, with the authority to adjust the dose or dosage form according to the patients' needs. The Review recommended that there should be provision for regular clinical review by the assessing clinician.

**[Note: the previous term Dependent Prescriber is now referred to as a Supplementary Prescriber]**

4. In a press release on 4 May 2001, the Minister for Health and Community Care announced the Scottish Executive's intention to allow supplementary prescribing by nurses and prescribing by other professions such as pharmacists following the enactment of the Health and Social Care Bill (see also paragraph 7 below). Ministers subsequently decided that the greatest benefit to the NHS and to patients would be the introduction of supplementary prescribing by nurses and pharmacists, following diagnosis by a doctor.

5. Between April and July 2002 the Health Department and the Medicines Control Agency (now part of the new Medicines and Healthcare products Regulatory Agency) consulted on the proposals for supplementary prescribing by nurses and pharmacists. Similar consultations took place in England, Wales and Northern Ireland. The results of the consultations were considered at meetings of the Committee on Safety of Medicines and the Medicines Commission in September 2002. Ministers considered their recommendations, and the Health Department's plans were set out in a press release issued on 21 November 2002.

### ***What is supplementary prescribing?***

6. The working definition of supplementary prescribing is "a voluntary partnership between an independent prescriber (a doctor or dentist) and a supplementary prescriber to implement an agreed patient-specific Clinical Management Plan with the patient's agreement".

### ***Legal basis of supplementary prescribing***

7. Section 63 of the Health and Social Care Act 2001 enabled the Government to extend prescribing responsibilities to other health professions. It also enabled the introduction of new types of prescriber, including the concept of supplementary prescriber, by allowing Ministers by Order to attach conditions to their prescribing. Section 42 (for England and Wales) and Section 44 (Scotland) also relate to dispensing by community pharmacists of prescriptions written by these new prescribers. Provisions in Northern Ireland are a matter for relevant NI legislation. Amendments to the Prescription Only Medicines Order and NHS regulations allow supplementary prescribing by suitably trained nurses and pharmacists.

### ***Aims of supplementary prescribing***

8. Supplementary prescribing is intended to provide patients with quicker and more efficient access to medicines, and to make the best use of the skills of trained nurses and pharmacists. Over time, supplementary prescribing is also likely to reduce doctors' workloads, freeing up their time to concentrate on patients with more complicated conditions and more complex treatments. Time spent initially developing a simple Clinical Management Plan, should be time saved when the patient returns for review to the supplementary prescriber rather than the doctor.

### ***Comparison with independent nurse prescribing and with Patient Group Directions***

9. Following training incorporated into their specialist practitioner programmes, District Nurse and Health Visitor independent prescribers can prescribe from the Nurse Prescribers' Formulary for District Nurses and Health Visitors: this comprises a limited list of medicines and a large number of dressings and appliances relevant to community nursing and health visiting practice.

10. “Extended Formulary” independent nurse prescribers undertake a longer specific programme of preparation and can prescribe from the Nurse Prescribers’ Extended Formulary. This includes all Pharmacy and General Sales List medicines prescribable by GPs on the NHS, together with a list of specified Prescription Only Medicines to treat conditions in four broad therapeutic areas – minor illness, minor injury, health promotion and palliative care.
11. **Patient Group Directions** are written instructions for the **supply** or **administration** of medicines to **groups** of patients *who may not be individually identified before presentation for treatment*. The Department has always made it clear that the majority of clinical care should be provided on an individual, patient-specific basis. Consequently the supply and administration of medicines under Patient Group Directions should be reserved for those situations where this offers an advantage for patient care (without compromising patient safety), and where it is consistent with appropriate professional relationships and accountability. Further detail is set out in NHS HDL (2001) 7.
12. **Supplementary prescribers** prescribe in partnership with a doctor or dentist (the independent prescriber). They are able to prescribe all medicines (with the current exceptions of Controlled Drugs, unlicensed drugs, unless they are part of a clinical trial which has a clinical trial certificate or exemption, and any restrictions set by Schedules 10 and 11 of the NHS (General Medical Services) Regulations). They may prescribe for the full range of medical conditions, provided that they do so under the terms of a patient-specific Clinical Management Plan (CMP). The Plan will be drawn up, with the patient’s agreement, following diagnosis of the patient by the independent prescriber, and following consultation and agreement between the independent and supplementary prescribers.

## **HOW SUPPLEMENTARY PRESCRIBING WILL WORK**

### **General principles**

13. The independent prescriber **must** be a doctor or dentist. It is for the independent prescriber to determine which patients may benefit from supplementary prescribing and the medicines that may be prescribed by the supplementary prescriber under the CMP. S/he will clearly need to take account of the professional relationship between the independent and supplementary prescriber as well as the experience and areas and degree of expertise of the supplementary prescriber when coming to a decision.
14. Supplementary prescribing is a partnership between the independent and the supplementary prescriber who, between them, should draw up and agree an **individual CMP** for the patient’s condition **before supplementary prescribing begins**. Sample draft templates are available on the Scottish Executive Health Department’s prescribing website: [www.show.scot.nhs.uk/sehd/nurseprescribing](http://www.show.scot.nhs.uk/sehd/nurseprescribing) and also attached as Annexes B

and C to this Guide, should help with this. The templates have been produced to **help** the NHS to develop CMPs more easily. The use of these templates is not mandatory. They can also be adapted/amended to suit local needs, or in some cases, it may be appropriate to develop CMPs from scratch. But there **must** be an individual CMP. Detailed information on what should be included in the CMP is set out in paragraph 43.

15. In each case the independent and/or supplementary prescriber should obtain the patient's agreement to supplementary prescribing taking place and then discuss and agree the CMP for that particular patient. The independent and supplementary prescribers must agree how to maintain communication, and that communication must be maintained, while the supplementary prescriber is reviewing and prescribing for the patient. They should ideally jointly carry out the formal clinical review at the agreed time – normally within a maximum of 12 months of the start of the CMP. (Periods longer than 12 months between joint clinical reviews or reviews by the independent prescriber may **occasionally** be acceptable in the CMP where the patient's condition has been shown to be stable and deterioration of the condition is not to be expected during a period longer than 12 months. The appropriateness of such a longer period between joint or independent prescriber clinical reviews is the responsibility of the independent prescriber though it must be agreed with the supplementary prescriber). If a joint clinical review is not possible, the outcome of the clinical review by the independent prescriber needs to be discussed with the supplementary prescriber, who must agree continuation of, or changes to, the CMP.
16. The independent prescriber should be the clinician responsible for the individual's care at the time that supplementary prescribing is to start. If this responsibility moves from one independent prescriber to another (for example from the patient's GP to a hospital consultant, or from one GP to another), the supplementary prescriber may **not** continue to prescribe, unless s/he negotiates and records in the patient record a new agreement to enter a prescribing partnership with the new independent prescriber. Supplementary prescribing partnerships involving more than one independent prescriber (e.g. shared care arrangements) are referred to in paragraph 22 below.

### ***Characteristics of supplementary prescribing***

17. The key characteristics of supplementary prescribing are:
  - Supplementary prescribing may **only** take place after a specified point in the individual patient episode, i.e. after assessment and diagnosis by an independent prescriber and the development of a written CMP agreed between the independent and supplementary prescriber.
  - The independent prescriber is responsible for the diagnosis and setting the parameters of the CMP, although they need not personally draw it up.

- The supplementary prescriber has discretion in the choice of dosage, frequency, product and other variables in relation to medicines only within the limits specified by the CMP. The Plan may include reference to recognised and authoritative clinical guidelines and guidance (local or national), whether written or electronic, as an alternative to listing medicines individually. Any guidelines referred to should be readily accessible to the supplementary prescriber when managing the patient's care.
  - Supplementary prescribing **must** be supported by a regular clinical review of the patient's progress by the assessing clinician (the independent prescriber), at pre-determined intervals appropriate to the patient's condition and the medicines to be prescribed. The intervals should normally be no longer than one year (and much less than this if antibiotics are to be included in the CMP). However, as stated in paragraph 15 above, longer periods, during which the patient continues to be reviewed by the supplementary prescriber, may be appropriate when the patient's condition is stable and is expected to continue to be stable.
  - The independent prescriber may, *at any time*, review the patient's treatment and/or resume full responsibility for the patient's care.
  - The independent prescriber and the supplementary prescriber **must** share access to, consult, keep up to date, and use, the same **common patient record** to ensure patient safety.
18. The key to safe and effective supplementary prescribing is the relationship between the individual independent prescriber and the individual supplementary prescriber. These two professionals should:
- Be able to communicate easily.
  - Share access to, consult, keep up-to-date, and use, the same common patient record.
  - Share access to the same local or national guidelines or protocols, where these are referred to in the CMP.
  - Agree and share a common understanding of, and access to, the written CMP.
  - Ideally, jointly review the patient's progress at agreed intervals.

### **Responsibilities**

19. The independent prescriber is responsible for:
- The initial clinical assessment of the patient, the formulation of the diagnosis and determining the scope of the CMP.
  - Reaching an agreement with the supplementary prescriber about the limits of their responsibility for prescribing and review – which should be set out in the CMP.

- Providing advice and support to the supplementary prescriber as requested.
- Carrying out a review of patient's progress at appropriate intervals, depending on the nature and stability of a patient's condition.
- Sharing the patient's record with the supplementary prescriber.
- **Reporting adverse incidents within local risk management or clinical governance schemes. NHS Quality Improvement Scotland (NHS QIS) have been asked to develop proposals for improving patient safety in Scotland, including how we might benefit from the work of the English National Patient Safety Agency (NPSA) in England (this is separate from Adverse Reaction Reporting – see paragraph 59-61 below).**

20. The supplementary prescriber is responsible for:

- Prescribing for the patient in accordance with the CMP. Altering the medicines prescribed, within the limits set out in the CMP, if monitoring of the patient's progress indicates that this is clinically appropriate.
- Monitoring and assessing the patient's progress as appropriate to the patient's condition and the medicines prescribed.
- Working at all times within their clinical competence and their professional Code of Conduct, and consulting the independent prescriber as necessary.
- Accepting professional accountability and clinical responsibility for their prescribing practice.
- Passing prescribing responsibility back to the independent prescriber, if the agreed clinical reviews are not carried out within the specified interval (see paras 15 and 17 above) or if they feel that the patient's condition no longer falls within their competence.
- Recording prescribing and monitoring activity **contemporaneously** in the shared patient record or as soon as possible – ideally within 24 to 48 hours.

### ***Working together***

21. Independent and supplementary prescribers must be willing and able to work together and to assume the specific responsibilities listed above.
22. Independent and supplementary prescribers may work in more than one prescribing partnership, providing that in each case they work as described above.

### ***The process***

23. Before starting to undertake supplementary prescribing, the supplementary prescriber will need to:
- Successfully complete the specified training and preparation for supplementary prescribing, including all assessments and the period of learning in practice.

- Ensure that their supplementary prescribing competency is recorded on the relevant Nursing and Midwifery Council professional register.
- Agree with the independent prescriber to enter into a prescribing partnership with them, and record that agreement in the patient's record.
- Agree the CMP for a patient with the independent prescriber.
- Make arrangements with their employer and/or the independent prescriber for access to prescription pads or other mechanisms for prescribing which are appropriate to the setting, for example patients' drug charts in hospitals.
- Arrange for access to an identified budget to meet the costs of their prescriptions.
- Reach agreement with their employer that supplementary prescribing should form part of their professional responsibilities.

### ***Conditions and health needs that can be included***

24. There are no legal restrictions on the clinical conditions that may be dealt with by a supplementary prescriber. Supplementary prescribing is primarily intended for use in managing specific chronic medical conditions or health needs affecting the patient. However, acute episodes occurring within chronic conditions may be included in these arrangements, provided they are included in the CMP.

### ***Patient consent***

25. Wherever it is proposed to manage a patient's condition through the use of supplementary prescribing, the principle underlying the concept of supplementary prescribing (i.e. a prescribing **partnership**) **must** be explained in advance to the patient by the independent or supplementary prescriber and their agreement should be obtained.
26. The agreement of the patient to the prescribing partnership should be recorded in the CMP and patient record. Without such agreement, supplementary prescribing may not proceed.

## **WHO CAN UNDERTAKE SUPPLEMENTARY PRESCRIBING?**

### ***Which nurses can be supplementary prescribers?***

27. A nurse supplementary prescriber must be a 1st level Registered Nurse or Registered Midwife whose name in each case is held on the NMC professional register, with an annotation signifying that the nurse has successfully completed an approved programme of preparation for supplementary prescribing.

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

28. The selection of nurses who will receive training in prescribing is a matter for local decision, in the light of potential benefits for patients and local NHS needs. No

nurse shall be required to undertake training unless s/he wishes to do so. All individuals selected for prescribing training **must** have the opportunity to prescribe in the post they will occupy on completion of training.

29. In addition to fulfilling the legal criteria for eligibility to prescribe, applicants who are selected for prescribing preparation will need to meet the following:
- Should have the ability to study at level 3 (degree level).
  - At least three years' post-registration clinical nursing experience. Nominees will usually be at E grade or above.
  - The support of their employer to confirm that:
    - their post is one in which they will have the need and opportunity to act as a supplementary prescriber;
    - for nurses in primary care, they will have access to a budget to meet the costs of their prescriptions on completion of the course;
    - they will have access to continuing professional development (CPD) opportunities on completion of the course.
30. There are likely to be many nurses in any local health organisation who meet these criteria. The three key principles that should be used to prioritise potential applicants are:
- patient safety;
  - maximum benefit to patients and the NHS in terms of quicker and more efficient access to medicines for patients;
  - better use of nurses' skills.

All programmes of preparation for nurses and midwives prepare them to be both independent and supplementary prescribers – there is no separate educational provision.

Only education programmes that meet the standards set by NMC and approved by NES in Scotland can lead to annotation on the professional register. Guidance from NES on education programmes in Scotland offers full information about the programmes. This is available via the NES website: [www.nes.scot.org.uk](http://www.nes.scot.org.uk)

## **TRAINING AND PREPARATION FOR SUPPLEMENTARY PRESCRIBING**

31. Nurses preparing to be supplementary prescribers will undertake a specific programme of preparation at degree level (level 3). This programme comprises at least the equivalent of 26 days with a Higher Education Institution plus 12 days “learning in practice”, during which a designated supervising medical practitioner will provide the student with supervision, support and opportunities to develop

competence in prescribing practice. The programme of preparation may be spread over a period of three to six months. Such nurses will also qualify to prescribe independently from the Nurse Prescribers' Extended Formulary. The nurse will also need to undertake an element of self-directed learning. Those nurses who have already qualified to prescribe from the Nurse Prescribers' Extended Formulary will only need to undertake the equivalent of an additional one to two days preparation on supplementary prescribing.

32. It will be for NHS organisations to determine which nurses to put forward for the programme of training and preparation.
33. In November 2002, the Nursing and Midwifery Council (NMC) agreed a set of standards for the preparation of nurse, midwife and health visitor prescribers. A copy of these is attached at Annex A. NHS Education for Scotland (NES) is responsible for quality assuring the specific programmes that Higher Education Institutions put forward for approval. Although some universities and pharmaceutical companies already offer training and education in aspects of pharmacology and medicines management, **only NES approved programmes of preparation for nurse prescribing will be accepted by NMC when recording a nurse's qualification.** Higher Education Institutions offering the specific programme of preparation **may** accredit the nurse's prior learning.
34. The programme will be part time over a period of up to six months. In addition to the time spent on the formal programme, it is important that employers of nurses undertaking the programme should recognise the demands of private study and provide support where necessary.
35. The programme for nurses and midwives includes an assessment of theory and practice that must be passed by nurses, before the student's entry on the NMC register can be annotated to indicate that they hold the prescribing qualification for Extended Formulary nurse prescribing and supplementary prescribing.
36. Central funding is being made available to meet the costs of training. NHS employers may also, of course, utilise their own training funds for this purpose.

### ***Preparation for independent prescribers***

37. It is highly desirable that independent prescribers who wish to take part in a supplementary prescribing partnership first undertake a short period of preparation related to the nature of supplementary prescribing and their responsibilities in the partnership. This will not necessarily require attendance at a Higher Education Institution: learning materials **may** be made available for use in the workplace.

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

38. All nurses have a professional responsibility to keep themselves abreast of clinical and professional developments. Supplementary prescribers will be expected to keep up-to-date with best practice in the management of conditions for which they may prescribe, and in the use of the drugs, dressings and appliances. Nurses may use the learning from this activity as part of their Post Registration Education and Practice (PREP-CPD) activity. NES has commissioned work on CPD that will be available from the autumn of 2003.

### **EVALUATION AUDIT AND CLINICAL GOVERNANCE OF SUPPLEMENTARY PRESCRIBING**

39. Supplementary prescribing needs to take place within a framework of clinical governance. Clinical supervision sessions for nurses provide an excellent opportunity for reflection on prescribing, as well as other aspects of practice. The model of clinical supervision should be agreed at local level, taking account of other staff support mechanisms and resources. It should be monitored and evaluated regularly.
40. A general review of supplementary prescribing arrangements should be carried out as part of the overall prescribing monitoring arrangements.
41. The supplementary prescriber together with his or her employer must put in place specific actions regularly to evaluate the safety, effectiveness, appropriateness and acceptability of their prescribing.
42. Other assistance with identifying audit methodologies and interpreting findings should be available through the employing organisations' normal clinical governance mechanisms.

### **THE CLINICAL MANAGEMENT PLAN (CMP)**

43. The Clinical Management Plan is the foundation stone of supplementary prescribing. *Before* supplementary prescribing can take place, it is *obligatory* for an agreed CMP to be in place (written or electronic) relating to a named patient and to that patient's specific condition(s) to be managed by the supplementary prescriber. This should be included in the patient record. Regulations specify that the CMP must include the following:
- The name of the patient to whom the plan relates.
  - The illness or conditions which may be treated by the supplementary prescriber.
  - The date on which the plan is to take effect, and when it is to be reviewed by the doctor or dentist who is party to the plan.

- Reference to the class or description of medicines or types of appliances which may be prescribed or administered under the plan.
- Any restrictions or limitations as to the strength or dose of any medicine which may be prescribed or administered under the plan, and any period of administration or use of any medicine or appliance which may be prescribed or administered under the plan.
- The arrangements in place for communication between independent and supplementary prescribers and for record maintenance.

**[NB: The CMP may include a reference to published national or local guidelines. However, these must clearly identify the range of the relevant medicinal products to be used in the treatment of the patient, and the CMP should draw attention to the relevant part of the guideline. The guidelines also need to be easily accessible]**

- Relevant warnings about known sensitivities of the patient to, or known difficulties of the patient with, particular medicines or appliances.
- The arrangements for notification of:
  - a) suspected or known reactions to any medicine which may be prescribed or administered under the plan, and suspected or known adverse reactions to any other medicine taken at the same time as any medicine prescribed or administered under the plan; and
  - b) incidents occurring with the appliance which might lead, might have led or has led to the death or serious deterioration of state of health of the patient.

**[See paragraph 59 about Adverse Reaction Reporting]**

- The circumstances in which the supplementary prescriber should refer to, or seek the advice of, the doctor or dentist who is party to the plan.

44. The CMP should be kept as simple as possible. It may refer to national or local evidence-based guidelines to identify the medicines that are to be prescribed, or circumstances in which dosage, frequency or formulation should be changed. There is no need to repeat the advice in these guidelines in the body of the CMP itself, nor need the CMP repeat detailed patient information that is contained in the patient's record shared by both prescribers, unless such information is essential for clarity and patient safety.
45. Following diagnosis by the independent prescriber, the independent and supplementary prescriber will probably need to discuss the CMP before the document itself is prepared. Either the independent or supplementary prescriber may draft the CMP; however, both must formally agree to the CMP before supplementary prescribing can begin. The agreement of the patient must also be sought, and that agreement recorded in the CMP. Without it, supplementary prescribing cannot proceed. [See paragraphs 25 and 26]

46. The independent prescriber and supplementary prescriber must share access to, consult and use, the same common patient record. Shared electronic records are ideal, but existing paper records or patient-held records can also be used. The CMP may need to contain different levels of detail, if the independent and supplementary prescriber work in different locations (e.g. a hospital-based independent prescriber and an outreach supplementary prescriber in the patient's home). Potential templates for CMPs can be found at Annexes B and C to this document, and have been posted on the Scottish Executive Health Department website: [www.show.scot.nhs.uk/sehd/nurseprescribing](http://www.show.scot.nhs.uk/sehd/nurseprescribing) – see also paragraph 14 above. The website will be updated as appropriate with advice on producing CMPs and other practical aspects of setting up a supplementary prescribing partnership.
47. It is for the independent prescriber to determine the extent of the responsibility he or she wishes to give to the supplementary prescriber under the CMP. The independent prescriber will clearly need to take account of the experience and areas of expertise of the supplementary prescriber, and the professional relationship between the independent and supplementary prescriber(s), when coming to this decision.
48. The CMP comes to an end:
- At any time at the discretion of the independent prescriber.
  - At the request of the supplementary prescriber or the patient.
  - At the time specified for the review of the patient (unless it is renewed by both prescribers at that time).
  - Where there is a sole independent prescriber and he or she is replaced for whatever reason. In these circumstances the CMP **must** be reviewed by their successor.

## **MEDICINES PRESCRIBABLE UNDER SUPPLEMENTARY PRESCRIBING ARRANGEMENTS**

49. The CMP may include any General Sales List, Pharmacy, or Prescription Only Medicine prescribable at NHS expense, **with the current exception of Controlled Drugs** (but see also paragraph 12 above). This **includes** the prescribing of:
- Antimicrobials.
  - “Black triangle” drugs and those products suggested by the British National Formulary to be “less suitable” for prescribing.
  - Products used outside their licensed indications (i.e. “off-label” use), provided that the product is licensed for use in the UK. Such use **must** have the joint agreement of both prescribers and the status of the drug should be recorded in the CMP.

NB. Unlicensed drugs (that is, a product that is not licensed in the UK) may be included in the CMP only where:

- a) a clinical trial is being undertaken under a clinical trials certificate or an exemption; and
- b) their use has the joint agreement of both prescribers and the status of the drug is recorded in the CMP.

50. The independent prescriber will need to be aware of the high-risk nature of many drugs prescribed under local shared care guidelines (e.g. Methotrexate) and the specific monitoring requirements to support the safe and efficacious use of these drugs. Before undertaking a supplementary prescribing arrangement involving any high-risk drug, the independent prescriber will need to assure him/herself that the supplementary prescriber has the level of skill/knowledge to take part in such an arrangement.
51. **A supplementary prescriber must not agree to prescribe any medicine if s/he feels that his/her knowledge of the medicines s/he may be asked to prescribe falls outside his/her area of competence.**

## **THE PATIENT REVIEW**

52. The patient review must take place after the interval stated in the CMP. This may be a joint review by both prescribers seeing the patient together. Where this is not possible, the independent prescriber should review the patient, and subsequently discuss future management of the patient's condition(s) with the supplementary prescriber. Both prescribers must record their agreement to the continuing or amended CMP, and the patient's agreement to the continuation of the supplementary prescribing arrangement, in order for the CMP to remain valid. They should then set a new date for review. Prescribing by the supplementary prescriber after the date of review, and without recorded agreement to the next phase of the CMP, should not continue.

## **GOOD PRACTICE, ETHICS AND ISSUES COMMON TO ALL SUPPLEMENTARY PRESCRIBERS**

### ***Stock items***

53. **In primary care settings, 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 through the GP10A stock order system.**

### **Informing patients**

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

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

55. This is a matter for the independent prescriber to decide when setting up the CMP. However, it is strongly recommended that (as for doctors and dentists) nurse supplementary prescribers should, wherever possible, not be placed in the position of prescribing for close family members, as judgement may be impaired and important clinical examination may be difficult/impossible. They should not prescribe for themselves.

## **PATIENT RECORDS**

61. 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 prescription details, together with other details of the consultation with the patient, should be entered into the record shared with the independent prescriber as soon as possible and preferably contemporaneously. It should be marked to indicate that it is the prescription of a supplementary prescriber, and should include the name of the supplementary 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 should be put into place at the same time as the supplementary prescribing partnership is set up. The record of the nurse's or midwife's prescription should also be entered into the nursing patient record (where a separate nursing record exists) at the time of writing.
57. 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 4 hourly 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 to be applied and how frequently changed are useful. It is recommended that the advice given on General Sales List (also known as "Over The Counter") items be recorded, although this is not mandatory.

58. In some circumstances, in the clinical judgement of the supplementary prescriber, it may be necessary to advise the independent prescriber immediately about the prescription. This action should be recorded in the common patient record.

## ADVERSE REACTION REPORTING

59. If a patient suffers a suspected adverse reaction to a prescribed, over-the-counter (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 (ADRs). The MHRA/CSM encourage the reporting of all suspected adverse drug reactions to newly licensed medicines that are under intensive monitoring (identified by a ▼ symbol 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 bound to the back of the British National Formulary). The supplementary prescriber should also inform the independent prescriber of any reported ADRs.
60. 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 supplementary 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)

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

61. **If a patient suffers harm due to an adverse incident involving medication, or if harm could have been caused to the patient (a near miss), the incident or near miss should be reported by the supplementary prescriber using both local and national reporting systems. The National Patient Safety Agency (NPSA), was established in England 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 NPSA information is shared with devolved health services in Scotland and Wales. The Agency will develop, implement and manage a new reporting system, which will collect information on adverse incidents and near misses so that lessons can be learnt at local and national level. It will develop solutions to try to ensure that the same errors are not repeated. NHS Quality Improvement Scotland has been asked to develop proposals to improve patient safety in NHSScotland, including how we might benefit from the work of the Agency. 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***

62. Where a nurse or midwife is appropriately trained and qualified and prescribes as part of their professional duties with the consent of their employer, the employer is held vicariously liable for their actions. In addition, nurse supplementary prescribers are individually professionally accountable to the Nursing and Midwifery Council (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.

### ***Professional indemnity***

63. All supplementary 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***

64. Where a GP practice is a dispensing practice, prescriptions from supplementary prescribers can be dispensed by the practice but only for the dispensing patients of that practice. Dispensing Doctors cannot dispense prescriptions written by supplementary prescribers for patients of other practices.
65. **When submitting prescription forms to Practitioner Services Division (PSD), dispensing practices should include them with their GP10 form count on their GP34 declaration and sort them as per existing instructions.**

66. Reimbursement for prescriptions written by supplementary prescribers can be claimed by Dispensing Doctors; payment for the prescriptions submitted will be made to the senior partner.

***Nurses required to dispense in primary care***

67. As stated within the NMC "*Guideline for the administration of medicines*" (2002), a nurse may be required to dispense "under exceptional circumstances". Where this is likely to occur, the nurse's employer should be aware of this practice. In addition, paragraphs 64-66 must be adhered to.
68. The rules for dispensing and reimbursement of supplementary prescribers' prescriptions are the same as for GP prescriptions.

## VERIFICATION OF PRESCRIBING STATUS

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

69. Dispensing pharmacists should ensure that they know the local procedure for resolving any queries with the supplementary prescriber or their independent prescriber partner.
70. To enable pharmacists to check whether a prescription handed in for dispensing is bona fide, all NHS employers should keep a list of all supplementary prescribers employed by them. It is also recommended that the employing authority hold 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*

71. Most enquiries from dispensing pharmacists will be resolved by telephoning the prescriber, or the prescriber's employer. 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.<sup>1</sup> 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 s/he 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.

## DISPENSING BY APPLIANCE CONTRACTORS

72. When a supplementary prescriber becomes aware that the patient intends to have a prescription dispensed by an appliance contractor, they must ensure that the prescription does not contain medicinal preparations (**Appliance contractors cannot dispense medicinal preparations**). Appliance contractors should submit as per existing instructions.

## URGENT DISPENSING

73. Occasionally prescriptions may require dispensing out of normal pharmacy opening hours. The prescription form should be endorsed by the prescriber with the word "Urgent". A pharmacist may claim an additional fee for dispensing a prescription urgently. Arrangements for dispensing out of normal hours vary, but details may be available via NHS organisations, local pharmacies, NHS 24 or police stations.

## DISPENSING OF ITEMS IN WALES AND NORTHERN IRELAND

74. Prescriptions written by supplementary prescribers in Scotland will only be dispensable by pharmacists in Wales and Northern Ireland when the devolved administrations amend their pharmaceutical regulations, to permit them to be dispensed at NHS expense.

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<sup>1</sup> Telephone number 020 7631 3200

## **DISPENSING ITEMS AGAINST A NURSE PRESCRIPTION IN HOSPITAL PHARMACIES**

75. An up-to-date list of all qualified supplementary 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.

### ***Prescribing information***

76. The Primary Care Information Group (PCIG) within the Information and Statistics Division (ISD) provides information on prescribed items and costs to their NHS organisations in the form of routine reports and in response to *ad hoc* requests. Supplementary prescribers can expect to receive information via their NHS employer which will help monitor their prescribing. Prescribing by nurse supplementary prescribers will be reported to NHS Organisations jointly with information on Extended Formulary prescribing. Requests for information should be made on headed note paper by the prescriber's NHS employer and sent to the following address:

**Primary Care Information Group  
Information and Statistics Division  
Trinity Park House  
South Trinity Road  
Edinburgh  
EH5 3SE**

77. Hospital employers may find it beneficial to collect and analyse prescribing data on supplementary prescribers alongside the routine monitoring of prescribing by doctors.

# ANNEX A

## **NURSING & MIDWIFERY COUNCIL**

### **The 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
Principles	<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>• <i>Reviews diagnosis and generates treatment options within the clinical treatment management plan</i></li>   <li>• Understand the complexity of the external demands and influences on prescribing</li> </ul>

Principal areas	Knowledge	Competence
Practice	<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>• <i>Relevant to own area of expertise</i></li>   <li>• Able to prescribe safely, appropriately and cost effectively</li>   <li>• <i>Understands how medicines are licensed, monitored</i></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>• <i>Able to refer back to a medical practitioner when appropriate</i></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>

Principal areas	Knowledge	Competence
Accountability	<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>   <li>• Requirements of record keeping</li>   <li>• Lines of communication</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>   <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>

Principal areas	Knowledge	Competence
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 practise 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>

# ANNEX B

## TEMPLATE CMP 1 (Blank): for teams that have full co-terminus access to patient records

Name of patient		Patient medication sensitivities/allergies		
Patient identification, e.g. ID number, date of birth				
Independent prescriber(s)		Supplementary prescriber(s)		
Condition(s) to be treated		Aim of treatment		
Medicines that may be prescribed by SP:				
<u>Preparation</u>	<u>Indication</u>	<u>Dose schedule</u>	<u>Specific indications for referral back to the IP</u>	
Guidelines or protocols supporting Clinical Management Plan:				
Frequency of review and monitoring by:				
Supplementary prescriber		Supplementary prescriber and independent prescriber		
Process for reporting ADRs				
Shared record to be used by IP and SP				
Agreed by independent prescriber(s)	Date	Agreed by supplementary prescriber(s)	Date	Date agreed with patient/carer

# ANNEX C

## TEMPLATE CMP 2 (Blank): for teams where the SP does not have co-terminus access to the medical record

Name of patient		Patient medication sensitivities/allergies		
Patient identification, e.g. ID number, date of birth				
Current medication		Medical history		
Independent prescriber(s)		Supplementary prescriber(s)		
Contact details: (tel/email/address)		Contact details: (tel/email/address)		
Condition(s) to be treated		Aim of treatment		
<u>Medicines that may be prescribed by SP</u>				
<u>Preparation</u>	<u>Indication</u>	<u>Dose schedule</u>	<u>Specific indications for referral back to the IP</u>	
Guidelines or protocols supporting Clinical Management Plan				
<u>Frequency of review and monitoring by</u>				
Independent prescriber		Supplementary prescriber and independent prescriber		
Process for reporting ADRs				
Shared record to be used by IP and SP				
Agreed by independent prescriber(s)	Date	Agreed by supplementary prescriber(s)	Date	Date agreed with patient/carer

# ANNEX D

## SUPPLEMENTARY PRESCRIBERS

### PART 1: REGISTRATION

#### **Registration with the Primary Care Information Group (PCIG) of the Common Services Agency Information & Statistics Division (ISD)**

1. Supplementary prescribers employed in the NHS Primary Care sector must be registered<sup>2</sup> with the Primary Care Information Group (PCIG). Employers are asked to use form ISD (P) 1 “Primary Care Nurse Prescribers: Registration or Change of Circumstances” for this purpose. (Form ISD (P) 1 is reproduced at Appendix 1.)
2. Form ISD (P) 1 should also be used to notify PCIG of any new or changed circumstances (e.g. change of name) for all nurse prescribers (HV/DN, Extended Formulary or Supplementary). Stocks of ISD (P) 1 will be distributed to all appropriate NHS offices as soon as possible. When they are received any remaining stocks of the previous notification form should be destroyed. (That form was included as an annex to “Extending Independent Nurse Prescribing within NHSScotland”) and known as Annex A.
3. The information requested on form ISD (P) 1 includes:
  - Supplementary prescriber’s profession and name;
  - Supplementary prescriber’s “personal identification number” provided by the NMC;
  - Details of the GP practice(s) where the supplementary prescriber’s patients are registered;
  - Organisation for which prescriber works (where relevant).

**NB. Employers must notify PCIG of each GP practice whose patients are served by the supplementary prescriber and identify the “principal prescribing practice” i.e. the GP practice for whose patients the supplementary prescriber will write the most prescriptions.**

4. On receipt of the correctly completed ISD (P) 1 a prescriber code will be allocated and ISD (P) 1 form will be returned to the lead nurse.

#### Changes to Prescriber Details

5. (i) It is the responsibility of employers to notify PCIG without delay of all relevant changes to prescriber details, e.g. change of name on marriage, etc. Form

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<sup>2</sup> Paragraph 8 of Schedule 2 to the NHS Act 1990.

ISD (P) 1 should also be used for this purpose. No change can be made to prescription stationery until formal notification is received.

- (ii) Any changes of prescriber details should be passed to the relevant NHS Board or Trust administrator within 48 hours (excluding weekends or Bank Holidays). This information should be passed to PCIG as specified in (i) above.

6. When completed, ISD (P) 1 should be sent by post to Primary Care Information Group, Information & Statistics Division, Trinity Park House, South Trinity Road, Edinburgh EH5 3SQ. This address is also printed on the form.

#### **Prescriber Ceases Employment / Prescribing**

7. PCIG must be advised immediately if a registered supplementary prescriber stops prescribing together with an appropriate reason e.g. because s/he has changed employer, retired, resigned, been suspended from the register or had her/his approval as a prescriber withdrawn.
8. In this situation, prescription stationery should be retrieved from the prescriber as a matter of urgency, and disposed of in accordance with the procedure outlined in Part 2 paragraph 11.
9. Notification is also required where the prescriber's employer is contracted to provide services for other commissioning organisations, e.g. nursing services through a Community Nurse Prescribing Contract. See also Part 2 paragraph 8 – "Non-NHS Employees".
10. Employers should annotate their lists of supplementary prescribers with the reasons for any changes to ensure that an up-to-date record exists.

## PART 2: PRESCRIPTION STATIONERY

### GP10N: Nurse Prescribers – Primary Care

1. Nurses working in primary care settings will prescribe using a GP10N form annotated, “EFNP/SUPPLEMENTARY PRESCRIBER” (copy attached at Appendix 4). The GP10N will be pre-printed with the prescriber’s name, nurse prescriber code, Nursing and Midwifery Council (NMC) number, practice address and contact telephone number.
2. EFNP/Supplementary prescribers who prescribe across more than one GP practice will be supplied with 2 different types of GP10N prescription pads. Pads issued in respect of the “principal prescribing practice” i.e. the practice for whose patients the greatest number of prescriptions will be written, will be pre-printed with all the details described above. See (Appendix 4). Prescription pads used for patients registered with any other GP practice will be printed with the prescriber’s name, NHS Organisation address, NMC number and contact telephone number. Prescribers will need to write the appropriate nurse prescriber code on each prescription form. See (Appendix 5.)

### Ordering GP10N Stationery

3. On receipt of form “Primary Care Nurse Prescribing: Registration or Change of Circumstances” (ISD) (P) 1 (Appendix 1) from PCIG the lead nurse will order a supply of stationery for the EFNP/Supplementary prescriber using form PSD 1, (Appendix 2), which should be sent to: Practitioner Services, Room D090, Trinity Park House, South Trinity Road, Edinburgh EH5 3SG.

### Nurse Prescribers – Secondary Care

4. Prescriptions can be written for hospital inpatients or outpatients using:
  - Hospital inpatient prescription forms or sheets – used for inpatients and discharge supplies only.
  - Internal hospital prescription forms – used for outpatients in cases where the hospital pharmacy dispenses the prescription.
  - HBPN prescription forms, used for prescriptions written by a hospital prescriber for dispensing by a community pharmacist.

**NB. Prescriptions written on internal hospital forms cannot be accepted for dispensing at community pharmacies.**

### Ordering HBPN Stationery

5. There is currently no requirement to notify PCIG of changes to the details of hospital-based supplementary prescribers. This is because no prescriber details are pre-printed on HBPN forms. (Copy attached at Appendix 6.)

6. (i) Once registered with the NMC as a supplementary prescriber, a nurse should inform her/his lead nurse who will arrange for the Chief Pharmacist to order a stamp containing the following information:
- EFNP/SUPPLEMENTARY PRESCRIBER
  - NMC number
  - Contact address and telephone number
  - Hospital/Department prescriber code.
- (ii) The Chief Pharmacist will also order HBPN forms by completing PSD 2 and forwarding it to: Practitioner Services, Room D090, Trinity Park House, South Trinity Road, Edinburgh EH5 3SG. Each prescription form will have to be stamped with the above information before use. (PSD 2 is reproduced at Appendix 3.)

### General Administrative Arrangements

7. Stationery supplies for NHS prescribers are normally distributed in bulk twice per year. Prior to each distribution a review of current prescribers is conducted by PSD with the help of NHS Boards/Trusts. In order to avoid errors each NHS Trust/Board is asked to complete the PSD Master List electronically.

### Non-NHS Employees

8. A non-NHS supplementary prescriber **cannot** issue a GP10 type prescription, ie one which will be dispensed in a NHS community pharmacy, **unless** the organisation they work for has an arrangement/contract with an NHS provider which allows the non-NHS organisation to use NHS community pharmacy dispensing services. The NHS provider should organise the supply of GP10-type prescription forms (and obtain the prescribing code(s) to be used) for the non-NHS organisation, if this is appropriate.

### Prescription Forms Ordered but not Delivered

9. Practitioner Services Division (PSD) should be informed about prescription stationery which is ordered, but not delivered. Contact:

<p>Moira Gardner Practitioner Services, Room D090 Trinity Park House South Trinity Road Edinburgh EH5 3SE</p>	<p>e-mail: moira.gardner@psd.csa.scot.nhs.uk Tel: 0131 551 8175 Fax: 0131 625 6236</p>
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## Security and Safe Handling of Prescription Forms: Good Practice

10. The security of prescription forms is the responsibility of both the employing organisation and the prescriber. Local policy should be established on monitoring the use of prescription forms to deter theft and fraudulent use. Employers should record the serial numbers of prescriptions issued to each prescriber, and to surgeries, clinics etc. It is also advisable to hold minimal stocks of prescription stationery. This reduces the number of forms vulnerable to theft, and helps to keep stocks up-to-date. (Prescription forms are normally revised annually.)
11. It is the responsibility of the employer to:
  - Recover and record all unused prescription forms relating to supplementary prescribers who leave their employment for whatever reason.
  - Send retrieved pads to stores with list of serial numbers.
  - Securely destroy retrieved pads by, e.g. shredding and placing in confidential waste.
  - Ensure that no further prescription pads are ordered for a prescriber who has left their employment or who has been suspended from prescribing duties.
  - Record the first and last serial numbers of the pads destroyed.
12. Each prescriber should keep a record of the serial numbers of prescriptions issued to him or her. The first and last serial numbers on each pad should be recorded. It is also good practice to record the number of the next unused prescription form on an in-use pad at the end of the working day. Such steps help to identify any forms that are lost or stolen.
13. Blank prescription forms must never be pre-signed and prescription pads should never be left unattended. In addition, prescription forms should not be left on a desk but placed in a locked drawer and produced when needed. Best practice is to return all unused forms 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.
14. All prescribers working in primary care should report the loss or theft of prescription stationery to their Primary Care Manager as soon as the theft/loss is discovered. The approximate number of prescription forms lost/stolen, their identification numbers, and where and when they were lost or stolen must be reported.
15. (a) The Primary Care Manager will immediately notify the Fraud Liaison Officer (FLO) who is responsible for informing local pharmacists and deciding on the action to be taken.

(b) The FLO should notify

Counter Fraud Services  
Stevenson House  
555 Gorgie Road  
Edinburgh  
EH11 3LG

Tel: 0131 536 5252  
Fax: 0131 536 5255  
Email: [gail.tait@psd.csa.scot.nhs.uk](mailto:gail.tait@psd.csa.scot.nhs.uk)

who will maintain a database of lost/stolen prescription forms.

16. Following a loss of prescription stationery the prescriber concerned will be asked to write and sign all prescription forms in a particular colour (usually red) for a period of two months. The employer will inform all pharmacies in their area and adjacent NHS areas of the name and address of the prescriber concerned, the approximate number of prescription forms lost/stolen and the period for which the prescriber will write in a specific colour. This advice will normally be put in writing within 24 hours, excepting weekends.
17. In the event of a loss or suspected theft, an Acute sector-employed prescriber should report this immediately to whoever issued the prescription forms (normally the hospital pharmacy) and the **local fraud specialist**. The prescriber should give details of the number of scripts 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 scripts in a particular colour (usually red) for a period of two months.
18. **NB.** All of the above requirements highlight the need for clear channels of communication, particularly between GP practices/PMS pilots and primary care systems.

# Appendix 1

Form: ISD (P) 1

## PRIMARY CARE NURSE PRESCRIBERS: REGISTRATION OR CHANGE OF CIRCUMSTANCES

Use this form to advise details of all categories of prescriber - nurse or midwife prescribers. For prescribers working across more than one practice please fill in one form per practice.\*

To: Primary Care Information Group, Trinity Park House, South Trinity Road, Edinburgh EH5 3SQ

From: NHS Board/Trust: .....

Tel: .....

Please tick appropriate box, below:

<input type="checkbox"/>	New nurse prescriber	(Complete sections A,B,C and D)
<input type="checkbox"/>	Change of name or PIN (NMC)	(Complete sections A and B)
<input type="checkbox"/>	Change of qualification to prescribe	(Complete sections A and B)
<input type="checkbox"/>	NHS Employment begins or ends	(Complete sections A,B,C and D)
<input type="checkbox"/>	Additional or change of practice	(Complete sections A,B,C and D)

Effective start date of prescribing or change  
(this box must be completed)

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### SECTION A:

Nurse (Delete as applicable)

		Details prior to change	Details of change
1	Surname		
2	Forename and Initials		
3	Job Title		
4	PIN (NMC)		
5	Unique Prescriber Code		
6	Formulary(DN/HV, Extended, Supplementary Prescriber)		

7 Prescriber's contact telephone number: .....

### SECTION B: Practice Details

		Details prior to change	Details of change
1	Practice Code or Code of Senior GP		
2	Practitioner/Senior GP name Practice Address. (Prescription Stationery will be forwarded to this address by the NHS Board/Trust.)		
4	Is this the prescriber's principal prescribing practice?*	Yes / No (Delete as applicable)	

\*For PCT nurses working across multiple practices only. The principal prescribing practice is where the majority of the patients for whom they write prescriptions are registered.

Please continue overleaf

PWI02909

**SECTION C: NHS Employer Details**

		Details prior to change	Details of change
1	Trust Name		
2	Trust Address		

**SECTION D: Prescriber Employment Details**

		Details prior to change	Details of change
1	Start date with Employer		
2	End date with Employer		

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**SECTION E: Details of person notifying registration:**

Please print Name .....

Contact Telephone Number: .....

Contact Address: .....

.....

.....

.....

Signature .....

Date .....

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PCIG use only	Prescriber code:	Date issued:
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# Appendix 2

Form: PSD 1

## NURSE ORDER FORM FOR GP10N

Return to: PSD, Room D090, Trinity Park House, South Trinity Road,  
Edinburgh EH5 3SG  
Tel: 0131 551 8175 Fax: 0131 625 6236

### TO BE COMPLETED BY NURSE PRESCRIBING LEAD NURSE:

From:  
Tel:

Prescriber's Surname: ..... Forename & Initials: .....

Contact Telephone Number: .....

NB: NO PADS WILL BE SUPPLIED IF A CONTACT TELEPHONE NUMBER IS NOT GIVEN

Please tick appropriate box:

NMC No.	<input type="text"/>	Nurse Supplementary Prescriber	<input type="checkbox"/>
Prescriber Code:	<input type="text"/>	Nurse DN/HV Prescriber	<input type="checkbox"/>
		Extended Formulary Nurse Prescriber	<input type="checkbox"/>
		Part Printed Pads	<input type="checkbox"/>

Does the nurse have a principal practice? Yes / No (if no, please specify below address where pad will be forwarded to).

Principal Practice  
(Pad will be forwarded to this address or the NHS Board/Trust)

.....  
.....  
.....  
Post Code .....

Address for pad delivery, if no principal practice:  
.....  
.....  
.....

Will the nurse be prescribing for more than one GP practice?

YES NO

--	--

If yes, how many practices? .....

-----  
Employer Address for delivery of order (i.e. NHS Board/Trust stores/pharmacy department):

.....

.....

.....

Post Code .....

-----  
Signed: ..... (Lead Nurse/Chief Pharmacist)

Please Print Name: .....

Date: .....

Tel: .....

-----  
**GUIDANCE NOTES:**

All prescription pads will be delivered to the employer at the address specified above.

The employer is responsible for onward distribution to the nurse/pharmacist prescriber.

Five pads will be supplied on completion of this form.

**GP10N**

All sections must be completed. Prescription pads will be delivered to the employer for forwarding to the nurse prescriber at the GP practice indicated on this form. (Whether or not a supplementary prescriber has a "principal practice", a GP practice address must always be provided.)

# Appendix 3

Form: PSD 2

## NURSE PRESCRIBERS: ORDER FORM FOR HBPN

Return to: PSD, Room D090, Trinity Park House, South Trinity Road,  
Edinburgh EH5 3SG  
Tel: 0131 551 8175 Fax: 0131 625 6236

### TO BE COMPLETED BY CHIEF PHARMACIST

Please indicate the number of pads required in the appropriate box, below.

HBPN Pads

Employer Address for delivery (i.e. stores/pharmacy department):

.....

.....

.....

Post Code .....

Signed: ..... (Chief Pharmacist)

Date: ..... Telephone Number: .....

Please Print Name: .....

---

### GUIDANCE NOTES:

#### Hospital-based Nurse Prescribers (HBPN)

The prescription pads ordered on this form will be delivered directly to the Trust at the Employer Address specified above. It is for the Trust to forward them to nurse supplementary prescribers at the appropriate hospital address.

# Appendix 4

FORM GP10N(2)		NATIONAL HEALTH SERVICE (SCOTLAND)	
Name		Address	
Age if under 12 yrs.	Postcode	Pharmacy Stamp	
Yrs / Mths	<input type="text"/>	Dispensing Endorsements	
No. of Days Treatment	<input type="checkbox"/> CHI No.	Pack size Numbers only	
	<input type="text"/>	<input type="text"/>	
		Pack size Numbers only	
		<input type="text"/>	
		Pack size Numbers only	
		<input type="text"/>	
Signature of Nurse	Date		
	XXXXX EFNP/SUPPLEMENTARY PRESCRIBER		
	A SMITH NMC 99X9999X		
	HEALTH CENTRE Tel: 9999 999 9999		
	1 MAIN STREET		
	ANYTOWN		
	XX99 9XX		
Please read notes overleaf and complete relevant parts BEFORE going to a pharmacy.			
00380038			

# Appendix 5

FORM GP10N(2)		NATIONAL HEALTH SERVICE (SCOTLAND)	
Name		Address	
Age if under 12 yrs.	Postcode	Pharmacy Stamp	
Yrs / Mths	<input type="text"/>	Dispensing Endorsements	
No. of Days Treatment	CHI No.	Pack size Numbers only	
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	
		Pack size Numbers only	
		<input type="text"/>	
		Pack size Numbers only	
		<input type="text"/>	
Signature of Nurse		Date	
<p>X _____ EFNP/SUPPLEMENTARY PRESCRIBER            A SMITH NMC 99X9999X            THE PRIMARY CARE TRUST Tel: 9999 999 9999            MAIN STREET            ANYTOWN            XX99 9XX</p>			
Please read notes overleaf and complete relevant parts BEFORE going to a pharmacy.			
00380038			

# Appendix 6

FORM HBPN(2)		NATIONAL HEALTH SERVICE (SCOTLAND)	
Name .....		.....	
Address .....		.....	
Age if under 12 yrs.	Postcode	.....	
Yes / Mths		Pharmacy Stamp	
No. of Days Treatment	CHF No.	Dispensing Endorsements	
<input type="checkbox"/>	.....	Pack size Numbers only	
		.....	
		Pack size Numbers only	
		.....	
		Pack size Numbers only	
		.....	
Nurse name in block capitals		.....	
Signature of Nurse		Date	
.....		.....	
Hospital or Clinic		Code No	
.....		.....	
Please read notes overleaf and complete relevant parts BEFORE going to a pharmacy.			
00500050			

# ANNEX E

## HOW TO COMPLETE THE PRESCRIPTION FORM

1. Detailed advice on writing prescriptions is contained in the British National Formulary (BNF) and the Nurse Prescribers' Formulary.
2. Information on the front of the prescription form should be written clearly and legibly using indelible ink (preferably black) or by printing using appropriate computer prescribing stationery and a computer prescribing system.
3. The information required is as follows:
  - The patient's title, forename, surname and address (including postcode) and if available the patient's Community Health Index (CHI) number.
  - The patient's date of birth, and age if under 12 years.

**NB. It is a legal requirement to write the patient's age on the prescription when prescribing Prescription Only Medicines for a child under 12 years of age.**

- If using computer prescribing systems the above information must be printed; for hand written prescriptions, enter if known e.g. from patient notes.
- For prescribing in primary care, and for patients whose prescriptions will be dispensed in the community, the prescription must contain the name of the prescribed item, formulation, strength (if appropriate) dosage and frequency, and quantity to be dispensed. The quantity prescribed should be appropriate to the patient's treatment needs, bearing in mind the need to avoid waste. Some medicines are only available in patient packs (or multiples thereof)<sup>2 3</sup> and special containers<sup>4</sup> and the pack (or multiple pack) quantity 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). Terms such as "1 Pack" or "1 OP" should not be used. Alternatively, for preparations to be given at a fixed dose and interval, the duration of treatment can be given in place of quantity to be dispensed.

---

<sup>2</sup> 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.

- In hospitals, prescriptions for inpatients 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.
- 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 Scottish 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 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).
  - The prescriber must sign and date the form.
  - On hospital prescriptions only: the nurse's name printed or hand written in the box provided, i.e. a contact name for the dispensing pharmacist.

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