

Non Medical Prescribing in Scotland

Guidance for Nurse Independent Prescribers

and for
Community Practitioner Nurse
Prescribers in Scotland

A Guide for Implementation

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Introduction

Introduction

Scope of this guidance and the effect of devolution

This guidance sets out the administrative and procedural steps needed to enable nurses and midwives to act as independent nurse prescribers, and provides information and advice on good practice. [N.B. where the term ‘nurse’ is used throughout the remainder of this document it includes midwives and specialist community public health nurses.]¹

The National Health Service (Pharmaceutical Services) (Scotland) Amendment (No. 2) Regulations 2006 set out the definition of ‘independent nurse prescriber’ as – a person who is registered in the Nursing and Midwifery Register, and against whose name in that register is recorded an annotation signifying that he or she is qualified to order drugs, medicines and appliances as a community practitioner nurse prescriber, a nurse independent prescriber or a nurse independent/supplementary prescriber.

This guidance sets out the steps to promote safe and effective prescribing by independent nurse prescribers in Scotland. Medicines legislation permits the introduction of independent prescribing for nurses in the UK, but it is for the devolved administrations in Scotland, Wales and Northern Ireland to decide whether and how it is implemented for the NHS in their countries.

BACKGROUND TO INDEPENDENT NURSE PRESCRIBING IN SCOTLAND

Brief history of nurse prescribing in Scotland

1. The nurse prescribing scheme for district nurses and health visitors was based on the recommendations contained in the Report of the Advisory Group on Nurse Prescribing 1989, which advised Ministers how patient care in the community might be improved by introducing nurse prescribing. The report identified a number of clear benefits that could arise from nurse prescribing:
 - an improvement in patient care;
 - better use of the patients’, nurses’ and GPs’ time;
 - clarification of professional responsibilities leading to improved communications between team members.

¹ From 2001, after the publication of Nursing for Health (2001), Edinburgh: HMSO, the term public health nursing includes both health visiting and school nursing in Scotland.

2. Implementation of DN/HV prescribing was piloted in England in 1994 and followed by its introduction in the other UK countries. The necessary legislation to enable community nurses in Scotland with either a district nursing or health visiting recordable qualification to prescribe from a limited (Nurse Prescribers') formulary was passed in 1996.²
3. The scheme was introduced in Scotland by a phased implementation, which commenced in 1996 and is now complete. It enabled all practising district nurses, health visitors and practice nurses with either qualification to undertake a course of preparation approved by the former National Board for Nursing, Midwifery and Health Visiting for Scotland (NBS). Since 2001, courses for independent nurse prescribing have been approved for the Nursing and Midwifery Council (NMC) by NHS Education for Scotland (NES).
4. Since 1999, preparation to prescribe from the Nurse Prescribers' Formulary was included in the district nursing and health visiting/public health nursing pathways of specialist practitioner programmes. Such prescribing is now integral to the education of all district nurses, health visitors/public health nurses and the small number of practice nurses who have successfully completed the assessment requirements of either the stand alone or integrated course and whose prescribing status is noted on the Professional Register held by the NMC.

Extending nurse prescribing

5. Following a 3-month consultation with nursing, medical and pharmacy professional organisations from October 2000, Ministers announced in May 2001 that nurse prescribing would be extended to include more nurses, and to a wider range of medicines, to cover four broad areas of practice: Minor ailments, Minor injuries, Health promotion, Palliative care.
6. The extension of nurse prescribing was intended to provide patients with quicker and more efficient access to medicines, and to make the best use of nurses' skills. The key principle underlying the extension was that patient safety was paramount.
7. Following training, nurses prescribing under this extended scheme were able to prescribe all General Sale List and Pharmacy Medicines prescribable by GPs under the then NHS (General Medical Services) (Scotland) Regulations – with the exception of those products which contained controlled drugs – together with a list of Prescription Only Medicines (POMs), listed in the Nurse Prescribers' Formulary.

² The Medicinal Products: Prescription by Nurses, etc. Act 1992 [which amended the National Health Service Act 1977 (section 41) and the Medicines Act 1968 (section 58)]; The Medicinal Products: Prescription by Nurses, etc Act 1992: (Commencement No 1) Order 1994; and in Scotland, Scottish Statutory Instrument, SSI No.1504, The National Health Service (General Medical Services Pharmaceutical Services and Charges for Drugs and Appliances) (Scotland) Regulations 1996.

8. Ministers also announced in May 2001 that steps would be taken to allow 'supplementary prescribing' by nurses and other health professionals, allowing them, after initial assessment of a patient by a doctor, to prescribe for that patient in accordance with a clinical management plan (CMP). This form of prescribing was thought to be particularly suitable for nurses working with patients with enduring conditions such as asthma, diabetes, heart disease or mental illness. A consultation document issued in April 2002 stated that nurses and pharmacists were to be the first professionals involved in supplementary prescribing.
9. In April 2003, the Government enabled nurses and pharmacists to undertake educational preparation as supplementary prescribers. Supplementary prescribing is defined as a voluntary partnership between the independent prescriber (a doctor or dentist) and a supplementary prescriber to implement an agreed patient-specific Clinical Management Plan, with the patient's agreement.
10. The University of Southampton completed an evaluation of nurse prescribing in England for the Department of Health early in 2005. It was clear from the evaluation's conclusions that nurses and some doctors felt that the format of the Nurse Prescribers' Extended Formulary was in some cases restricting benefit to patients and efficient NHS practice. Experience had also shown that updating the Extended Formulary was a long and resource intensive process, with proposed changes taking 12 to 17 months to put into effect. Furthermore, supplementary prescribing could not be used in all settings where patients would benefit, e.g. emergency care and first contact care, because it required the development of an individual CMP agreed with a doctor/dentist.
11. A joint Department of Health / Medicines and Healthcare products Regulatory Agency consultation from February to May 2005 examined the options for the future of independent nurse prescribing. At the same time, a similar consultation examined options for the introduction of independent prescribing by pharmacists. These proposals aimed to benefit patients by providing greater access to pharmacists' knowledge and expertise, and a faster and more accessible service.
12. The responses to both consultations were considered by the Committee on Safety of Medicines who recommended to Ministers that suitably trained and qualified nurses should be able to prescribe any licensed medicine for any medical condition within their competence. These recommendations were agreed by Ministers and announced in a press release on 10 November 2005.
13. Changes to regulations in May 2006 enable nurses who train and qualify as 'nurse independent prescribers', to be able to prescribe any licensed medicine (i.e. products with a UK marketing authorisation) for any medical condition they are competent to treat.

14. Nurse independent prescribers can prescribe a limited range of Controlled Drugs for specific medical conditions. [N.B. – See also para 90 on Controlled Drugs and Appendix 9.]
15. Within the Scottish context, the University of Dundee was commissioned by the Scottish Executive to undertake a 'Research Literature Review on Prescribing'. Jane Harris et al (2004) examined research studies for the period 2000 – 2003. Two key findings from this review were firstly, that further research was needed to evaluate the impact of different models of prescribing on patient care and the effectiveness of educational preparation for the prescribing role. Secondly, a more judicious approach to the use of patient group directions (PGDs – see Appendix 13) was needed.
16. Further research by Stirling University is in progress to undertake an 'evaluation of the extension of independent nurse prescribing in Scotland'. The final report of this staged study will be in 2007. The quantitative assessment from the survey data on individual nurse prescribers in Scotland captures information on: professional biographical information, age, gender, qualifications, how long each has qualified and worked as a nurse prescriber, and information on workloads, job satisfaction, and impact on patients. Further evaluation work is planned and will involve interviews with nurse prescribers, patients, carers and relatives, GPs, pharmacists and managers. This work will influence the implementation and delivery of nurse prescribing in Scotland.

Current nurse prescribers

17. District Nurses and Health Visitor/Public Health Nurse prescribers (NMC V100) will continue to be entitled to prescribe from the current Nurse Prescribers' Formulary for community practitioners in the British National Formulary (BNF). The formulary will be regularly reviewed, kept up to date and in line with practice requirements. These professionals will in future be called 'community practitioner nurse prescribers' (see paragraph 28).
18. There are a small number of nurses who under the old system qualified as 'extended formulary' nurse prescribers (NMC V200), who have not undertaken the top-up training which allows them, additionally, to act as supplementary prescribers. They will however be entitled to act as 'nurse independent prescribers' in the new system (see paragraph 29).
19. The nurses who have qualified as 'extended formulary' nurse prescribers and as 'supplementary prescribers' (NMC V300) will be entitled to act as 'nurse independent prescribers' or as 'supplementary prescribers', as appropriate (see paragraphs 29 – 31).

Definition of independent prescribing

20. A working definition of independent prescribing is prescribing by a practitioner (e.g. doctor, dentist, nurse, pharmacist) responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing. Within medicines legislation the term used is 'appropriate practitioner'.
21. In partnership with the patient, independent prescribing is one element of the clinical management of a patient. It requires an initial patient assessment, interpretation of that assessment, a decision on safe and appropriate therapy, and a process for ongoing monitoring. The independent prescriber is responsible and accountable for at least this element of a patient's care. Normally prescribing would be carried out in the context of practice within a multidisciplinary healthcare team, either in a hospital or in a community setting, and within a single, accessible healthcare record.

Legal basis of independent prescribing by nurses

Nurse Prescribing, in Scotland, has progressed, since 1996 as shown in the chart entitled 'History of nurse prescribing' (see Appendix 14).

22. The initial legal basis for the introduction of nurse prescribing was provided for in reserved legislation and in NHS regulations. See paragraph 2. In Scotland, the Scottish NHS regulations underpinning the subsequent introduction of nurse supplementary prescribers and nurse independent prescribers are set out below:

Supplementary Prescribing (2003):

- The National Health Service (Pharmaceutical Services) (Scotland) Amendment Regulations 2003. SSI No. 296
- The National Health Service (Charges for Drugs and Appliances) (Scotland) Amendment (No. 2) Regulations 2003. SSI No. 295
- The National Health Service (General Medical Services) (Scotland) Amendment (No. 3) Regulations 2003. SSI No. 443

Nurse Independent Prescribing (2006):

- The National Health Service (Pharmaceutical Services) (Scotland) Amendment (No. 2) Regulations 2006. SSI No. 245
 - The National Health Service (Charges for Drugs and Appliances) (Scotland) Amendment (No. 2) Regulations 2006. SSI No. 246
 - The National Health Service (General Medical Services) (Scotland) Amendment Regulations 2006. SSI No. 337
23. Section 63 of the Health and Social Care Act (2001) enabled the Government to extend prescribing responsibilities, including supplementary prescribing, to other health professions.
24. Amendments to the Prescription Only Medicines (Human Use) Order 1977 (the POM Order) and associated medicines regulations enable nurses against whose names in the Nursing and Midwifery Council Register is an annotation to act as nurse independent prescribers or nurse independent/supplementary prescribers. These nurses may prescribe any licensed medicine, (i.e. products with a UK marketing authorisation) including some Controlled Drugs, for any medical condition within their clinical competence (see paragraphs 29 – 31).

Aims of independent prescribing by nurses

25. Government policy is to extend prescribing responsibilities to non-medical professions to:
- improve the quality of service to patients without compromising patient safety;
 - make it easier for patients to get the medicines they need;
 - increase patient choice in accessing medicines;
 - make better use of the skills of health professionals;
 - contribute to the introduction of more flexible team working across the NHS.
26. Independent prescribing by nurses aims to provide patients with quicker and more efficient access to medicines, and to make the best use of their skills, knowledge and expertise. Independent prescribing by nurses will also allow doctors to make better use of their expertise.

27. NHS Boards should develop their strategic plan for non-medical prescribing to include independent prescribing by nurses and pharmacists. Typically this would involve senior managers and clinicians (doctors, nurses, pharmacists) and the drug and therapeutics committee (or equivalent). The plan should be approved at Board level and would, for example:
- recognise the benefits to patients of non-medical prescribing;
 - identify an initial range of clinical areas where patients could benefit;
 - identify a way to support and sustain the transition of staff to extended roles and the services they currently provide;
 - develop a communications plan aimed at informing both patients and all clinical and managerial staff;
 - include timescales for implementation;
 - identify a lead director to be responsible for implementation.

Different categories of nurse prescriber

'Community Practitioner Nurse Prescribers'³

28. On successful completion of a community specialist practitioner programme which incorporates 'community practitioner nurse prescribing'⁴ such nurses can prescribe from the Nurse Prescribers' Formulary for Community Practitioners.⁵ This Formulary includes dressings, appliances and a limited list of medicines relevant to community nursing and health visiting/public health nursing practice. Applicants for the preparation programme (Specialist Practitioner Qualification/Specialist Community Public Health Nurse Qualification) for community practitioner prescribing from the Nurse Prescribers Formulary for Community Practitioners must provide evidence of meeting the NMC criteria for eligibility to undertake an integrated prescribing programme as part of the Specialist Practitioner/Specialist Community Public Health Nursing Award. The criteria are that:
- nurses must be registered as a nurse and/or midwife;
 - applicants intend to practise in an area of clinical need for which prescribing from the Community Practitioner Formulary will improve patient/client care and service delivery.

³ Community practitioner nurse prescribers cannot prescribe controlled drugs or act as supplementary prescribers otherwise the guidance in paragraphs 70 – 118 is relevant.

⁴ Formerly District Nurse and Health Visitor/Public Health Nurse prescribing.

⁵ Previously called the Nurse Prescribers' Formulary for District Nurses and Health Visitors.

'Nurse Independent Prescribers'

29. Nurse independent prescribers will be able to prescribe any licensed medicine (i.e. products with a UK marketing authorisation) for any medical condition, including some controlled drugs. Nurse independent prescribers must only ever prescribe within their own level of experience and competence, acting in accordance with Clause 6 of the NMC (2002) Code of Professional Conduct.⁶
30. Supplementary prescribers⁷ can prescribe in partnership with a doctor or dentist. Nurse 'supplementary prescribers' are able to prescribe any medicine, including a limited range of Controlled Drugs and unlicensed medicines⁸ that are listed in an agreed CMP. All supplementary prescribers may prescribe for any medical condition, provided that they do so under the terms of a patient-specific CMP which will be drawn up, with the patient's agreement, following diagnosis of the patient, and following consultation and agreement between the doctor and the supplementary prescriber.
31. Supplementary prescribing may still be the most appropriate mechanism for prescribing in some instances, e.g. where a nurse is newly qualified as a prescriber or where a team approach to prescribing is clearly appropriate, or where a patient's CMP includes certain controlled drugs or unlicensed medicines. The NMC (2006)⁹ Practice Standard 8 should be followed by nurse prescribers in such situations. See also paragraph 94 and Appendix 11.

In future, nurses will be prepared as both 'nurse independent prescribers' and 'supplementary prescribers' (described by the NMC¹⁰ as nurse independent/supplementary prescribers) in the new arrangements. This document refers to this group of practitioners as 'nurse independent prescribers'.

6 NMC (2002) Code of Professional Conduct: standards for conduct, performance and ethics. London: NMC.

7 Nurses, pharmacists, physiotherapists, radiographers, podiatrists and optometrists.

8 See paragraph 67 and Appendix 13 for further information.

9 NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

10 NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

Nurse Independent Prescribers

Nurse Independent Prescribers

Which nurses can act as ‘nurse independent prescribers’?

32. A nurse independent prescriber must be a registered first level nurse, midwife and/or specialist community public health nurse whose name is held on the NMC professional register, with an annotation signifying that the nurse has successfully completed an approved programme of preparation and training for nurse independent prescribing.

Selection of nurses for an approved programme of preparation

33. The selection of nurses (see paragraph 73) to receive training in prescribing is a matter for employing organisations who are best placed to assess local service and patient needs, and ensure fit with NHS Board strategic plans (see paragraph 27).

All individuals selected for prescribing training must have the opportunity to prescribe in the post that they will occupy on completion of training. The therapeutic area in which they will prescribe should also have been identified before they begin training to prescribe. Almost certainly this will be in the field in which they already hold considerable expertise.

The NMC (2006)¹¹ have published Standards of Proficiency for nurse and midwifery prescribers which contain the requirements for admission to programmes leading to the nurse independent/supplementary prescribing qualification.

34. Applicants must provide evidence of meeting NMC criteria for eligibility to undertake educational preparation for nurse independent/supplementary prescribing as summarised below:
- Nurses should be able to study at degree level (Scottish Credit and Qualifications Framework, level 9) evidenced through the Accreditation of Prior Experiential Learning (APEL), or the Accreditation of Prior Learning (APL) process.
 - At least three years’ post-registration clinical nursing experience, of which at least one year immediately preceding their application to the training programme should be in the clinical area in which they intend to prescribe. Part-time workers must have practised for a sufficient period to be deemed competent by their employer.¹²

¹¹ NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

¹² NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

- Nurses must be assessed by their employer as clinically competent in the area in which they wish to prescribe. For example, they must be able to carry out a comprehensive assessment of the patient's physiological and/or psychological condition and understand the underlying pathology and the appropriate medicines regime. It is:
 - the combination of expertise in the condition being treated
 - appreciation of the patient's particular manifestation of it
 - the medicines which will be effective that make a proficient and competent prescriber.
- Have written confirmation from a designated medical practitioner who meets the eligibility criteria described by the National Prescribing Centre¹³ that s/he has agreed to facilitate learning and assess competence during the learning in practice element of the education programme.
- Applicants will also need written confirmation from their employer that:
 - their post is one in which they will have the need and the opportunity to act as a nurse independent prescriber immediately upon qualifying
 - they will have access to a budget to meet the costs of their prescribing on completion of the course. This applies to nurses in all settings (community, primary care, acute, out-of-hours, unscheduled care, etc.)
 - they will have access to continuing professional development (CPD) opportunities on completion of the course
 - there has been prior agreement about the therapeutic area in which they will prescribe
 - the nurse independent prescribers will work within a robust clinical governance framework (see para 73).

¹³ NPC (2005) Training non-medical prescribers in practice. Liverpool: NPC.

35. There are likely to be many nurses in any local health economy who meet these criteria. The three key principles that should be used to prioritise potential applicants are:

- patient safety;
- maximum benefit to patients and the NHS in terms of quicker and more efficient access to medicines for patients;
- best use of the nurses' skills.

No nurse shall be required to undertake training unless s/he wishes to do so, and individual practitioners must also understand and accept the higher level of clinical responsibility associated with prescribing.

36. The Scottish Executive considers nurse prescribing to be a significant driver of change,¹⁴ (also see paragraphs 25-26), and it is anticipated that the benefits of nurse prescribing go well beyond community and primary care. It is expected that nurses from all settings will become nurse independent prescribers and thus deliver improved services and better outcomes for patients. NHS Board strategic plans must embrace this whole systems approach (see also paragraph 27).

Central funding for approved education programmes for nurse independent/ supplementary prescribing

37. Central funding will continue to be made available to prepare nurses for prescribing. This funding will be allocated on the basis of named lists of nurses which have been nominated by NHSScotland NHS Boards who have prioritised nurses for training. The Scottish Executive will also take account of remote rural issues when allocating funding. Central funding currently includes a contribution to other costs incurred by employers in addition to the course fees. However, this funding is not guaranteed, and depends upon the fees set by Higher Education Institutions.

38. The central funding allocated for the above is intended to benefit patients and their access to medicines in the NHS. Training for nurses employed by NHS bodies (e.g. NHS Board employees, GP practices) can therefore be funded from this resource.

14 Scottish Executive (2005) Framework for developing nursing roles. Edinburgh: SEHD.

Non-NHS staff

39. Nurses employed by non-NHS organisations, and who provide the majority of their clinical services to NHS patients (e.g. nurses working in hospices and prisons) may have their training funded from the above.
40. In nominating for training any nurses whose posts are directly or indirectly funded by pharmaceutical and other companies, employers should be aware of, and take necessary steps to remove, any conflicts of interests that may subsequently arise in the nurse's practice.
41. Nurses are reminded of the Code of Professional Conduct (NMC 2002),¹⁵ Clause 7.2, which states that, in the exercise of her/his professional accountability, a registered nurse must 'ensure that your registration status is not used in the promotion of commercial products or services, declare any financial or other interests in relevant organisations providing such goods or services, and ensure that your professional judgement is not influenced by any commercial considerations'.

Funding from other sources

42. There is no reason why an NHS organisation or a private organisation should not pay for the preparation of more nurses and midwives by identifying other sources of funding.

¹⁵ NMC (2002) Code of Professional Conduct. London: NMC

Educational Preparation

Educational Preparation for Nurse Independent Prescribing

43. The NMC has set out standards for the educational preparation of nurses for prescribing¹⁶ and will only approve programmes in Approved Education Institutions (AEIs) which meet these standards (see www.nmc-uk.org). Currently, NES undertakes all aspects of quality assurance on behalf of the NMC in Scotland.
44. Eligibility to prescribe requires successful completion of an NMC approved programme of preparation at no less than degree level (SCQF, level 9). The education programme includes nurse independent and supplementary prescribing and consequently all successful candidates will qualify as nurse independent/supplementary prescribers. The programme comprises a minimum of 26 days of theoretical learning plus 12 days 'learning in practice'. A designated medical practitioner will provide the student with supervision, support and opportunities to develop competence in prescribing practice during the learning in practice element of the programme. Programmes will be no longer than one academic year.
45. For distance learning programmes, there must be a minimum of 8 face-to-face taught days (excluding assessment) plus 10 days protected learning time. In exceptional circumstances, where this is not practical, video-conferencing in which interaction between all participants is possible, will be acceptable.
46. The education programmes include an assessment of theory and practice which must be successfully completed before the student's entry on the NMC register is annotated, to indicate that s/he holds a qualification for prescribing.
47. Individual Higher Education Institutions, where appropriate, may use approved prior learning (APL), to give credit for a nurse's previous learning, and improve courses based on research findings.

Supervising and the Designated Medical Practitioner (DMP)

48. Guidance entitled 'Training non-medical prescribers in practice – A guide to help doctors prepare for and carry out the role of designated medical practitioner' is available on the National Prescribing Centre website at: www.npc.co.uk and should inform the selection of Designated Medical Practitioners (DMPs) (see Appendix 13).
49. The period of learning in practice (see above, paragraphs 44 and 45) is to be directed by a DMP, who will also be responsible for assessing whether the learning outcomes have been met and whether the trainee has acquired all competencies. These outcomes and competencies will be identified by the Higher Education Institution (HEI), running individual courses.

¹⁶ NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC.

50. The DMP has a critical and highly responsible role in educating and assessing the non-medical prescriber and assuring competence in prescribing.
51. Before taking on the role of DMP, the doctor and the HEI should consider the implications of undertaking this role safely and effectively. It is then important that the DMP and the HEI running the prescribing programme should work closely together.
52. Preparing new prescribers will undoubtedly take up some time. The approach to teaching and learning should be developed on an individual basis, so it is difficult to predict how much time this will involve. It is unlikely that the student prescriber will need to spend all of the period of learning in practice with the DMPs, as other clinicians may be better placed to provide some of the learning opportunities.
53. Registrants undertaking educational preparation to prescribe as nurse independent/supplementary prescribers must successfully complete a range of assessment strategies to demonstrate that they have met the required learning outcomes relevant to the scope of their prescribing responsibilities. Competence will be demonstrated through an assessment of theory and practice, and a range of assessment strategies will be employed to test knowledge, decision-making and the application of theory to practice.
54. The assessment of practice is the responsibility of the DMP who remains responsible for assessing whether all the learning outcomes have been met, and verifying by the end of the course that the student is competent to assume the prescribing role.

Continuing Professional Development (CPD)

55. All nurses have a professional responsibility to keep themselves abreast of clinical and professional developments. This is no less true for prescribing. All nurse prescribers including nurse independent prescribers will be expected to keep up to date with evidence and best practice in the management of the conditions for which they prescribe, and in the use of the relevant medicines. See NMC (2006) Practice Standard 13¹⁷ on evidence-based prescribing. It is for each nurse independent prescriber to remain up-to-date with knowledge and skills to prescribe competently and safely. Also see NMC (2006) Practice Standard 15¹⁸ on continuing professional development.

17 NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

18 NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

56. Nurses may use the learning from this activity as part of their Post Registration Education and Practice (PREP-CPD) activity. The employer should ensure that the practitioner has access to relevant education and training provision. It is good practice for employers to support these prescribers in pursuing self-directed study. Details of additional training and updating will need to be incorporated by the individual into their personal professional profile, in order to renew their registration with the NMC.
57. NES¹⁹ has developed a CPD competency framework for all qualified prescribers to support individual practitioners to maintain their skills and competencies. Individual teams or organisations can also use this template to record and identify learning.
58. 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. Employers may also consider providing mentoring opportunities and clinical supervision for these nurses (see paragraph 74).
59. Continuing Professional Development is an important element of clinical governance, crucial to ensure quality care and patient safety (see paragraph 104 also).

Buddying and mentorship

60. Support from other professional colleagues is invaluable to non-medical prescribers, especially to those who are newly qualified. Many non-medical prescribers already have a buddy/mentor after qualifying: this could be a doctor, nurse or pharmacist. Opportunities for experienced (nurse) prescribers to mentor nurses will increase, over time, as the number of nurse independent prescribers increases.
61. Supplementary prescribing is also a useful mechanism to enable new non-medical prescribers to develop expertise and confidence. Core personal formularies/local formularies may be a system that nurse independent prescribers would wish to develop in agreement with local management and the prescribing budget holder.

19 NES (2003) A template for continuing professional development in prescribing. Edinburgh: NHS Education for Scotland.

Medicines Prescribable

Medicines Prescribable under Nurse Independent Prescribing

Prescribing within competence (See also Appendices 4-8)

62. All nurse independent prescribers must work only within their own level of professional competence and expertise, and must seek advice and make appropriate referrals to other professionals with different expertise. Nurses are accountable for their own actions, and must be aware of the limits of their skills, knowledge and competence.
63. Nurses must act within Clause 6 of the NMC (2002)²⁰ Code of Professional Conduct. All prescribing nurses should be aware of and follow the NMC (2006) Standards of Proficiency for nurse prescribers.²¹

Controlled Drugs

64. Suitably qualified nurse independent prescribers can prescribe any licensed medicine (i.e. products with a UK marketing authorisation) for any medical condition, including some controlled drugs. Nurse independent prescribers are able to prescribe the list of controlled drugs at Appendix 9, solely for the medical conditions indicated. Local clinical governance systems need to be put in place to monitor and support prescribing generally, and specifically for controlled drugs (see paragraphs 66 – 73). Medicines management teams and pharmacy guidance are required to advise on national and local policies.

Prescribing medicines used outside the terms of their licence (off-label)

65. Nurse independent prescribers can prescribe medicines independently for use outside their licensed indications/UK marketing authorisation (so called 'off-licence' or 'off-label'). See NMC (2006)²² Practice Standard 18.
66. Nurse independent prescribers must however, accept clinical/legal responsibility for that prescribing, and should only prescribe off-licence/off-label where it is accepted clinical practice. A local policy for the use of off-licence medicines should be approved through mechanisms such as Drug and Therapeutic Committees. The prescriber should explain the situation to the patient/guardian, where possible, but where a patient is unable to agree to such treatment, the prescriber should act in accordance with best practice in the given situation and within the policy of the employing organisation.

20 NMC (2002) Code of Professional Conduct: standards of conduct, performance and ethics. London: NMC

21 NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

22 NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

Unlicensed medicines (products without a UK marketing authorisation)

67. You must not prescribe an unlicensed medicine as a nurse independent prescriber. See NMC (2006)²³ Practice Standard 17 and Appendix 11.

Borderline Substances

68. All NHS prescribers will need to abide by any NHS terms of service under which they operate. For example, if operating under the new GMS, borderline substances may be prescribed but the prescription will need to be marked 'ACBS'. A list of ACBS (Advisory Committee on Borderline Substances) approved products and the circumstances under which they can be prescribed, can be found in the British National Formulary. Although this is a non-mandatory list, nurse independent prescribers should normally restrict their prescribing of borderline substances to items on the ACBS approved list. They should also work within the guidance of their employing organisation.

Appliances and dressings in the Scottish Drug Tariff

69. Nurse independent prescribers, in primary care, can also prescribe any appliances/dressings that are listed in the Scottish Drug Tariff. Nurses prescribing in secondary care are not restricted to prescribing appliances/dressings from the Tariff.

²³ NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

Clinical Governance

Clinical Governance in Independent Prescribing

Role of the employer in NHS organisations

70. Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.
71. Chief Executives and Independent Contractors are legally accountable for the quality of care that patients receive and for securing patient safety.
72. When properly implemented, clinical governance provides a framework for enabling nurses who have qualified as independent prescribers, to practice safely, competently and in the interests of patients.
73. The employing organisation must ensure that nurse independent prescribing is included within NHS Board strategic plans (see paragraph 27) and their overall clinical governance framework to ensure that nurses and pharmacists practise safely and competently. The clinical governance framework must include systems for:
 - selection – all entrants to prescribing training must be selected according to criteria indicating their potential to prescribe safely in the area in which they will practise. This will usually include evidence that they have appropriate specialist knowledge and an opportunity to prescribe within their work (see para 34)
 - completion of accredited education programmes – the regulatory bodies provide and assess the standards for training and education programmes. Employers also have a duty to ensure that those training to prescribe are supported through their programme (see paras 43 – 54)
 - NMC register-checking procedures need to be in place for new employees, permanent staff required to maintain their registration, and nurse independent prescribers from other countries. Thus employers will ensure that the names of prescribers are annotated on their professional register before they begin to prescribe (see appendices 1 and 2)
 - ensuring that arrangements are in place for assessment of practice, clinical supervision, audit, and continuing professional development for all nurse independent prescribers (see paras 53 – 59)

- developing a risk management plan – this will ensure potential risks associated with extending clinical practice are recognised and action taken to minimise the impact. Systems need to be set up by employers to ensure nurse prescriber details and changes are given to HIG / ISD, and prescription forms handled securely and safely (see Appendices 3 – 4 and 7 – 8)
 - ensuring that the parameters of an individual's prescribing are agreed between the prescriber and their employer, and ensuring that Drug and Therapeutic Committees and Information Services Division (ISD), are aware of the medicines being prescribed by the Nurse Independent Prescribers.
74. Nurses should use clinical supervision arrangements or equivalent as an opportunity for reflection on prescribing, as well as other aspects of practice (see paragraphs 56 – 58). The model of clinical supervision should be agreed at local level, taking account of other staff support mechanisms and resources.
75. A review of independent prescribing by nurses should be carried out as part of the overall prescribing monitoring arrangements and as a suitable area of practice for regular audit. This should include prescription and cost data (e.g. PRISMS). In hospital settings, nurse independent prescribers will come under the same systems of scrutiny and monitoring as other prescribers (see para 105).

Independent and the private sector

76. Nurse independent prescribers who work outside NHS settings where clinical governance systems may be different or may not be applied in the same way, must ensure they comply with requirements to demonstrate their competence to practise. For example, they must be able to show how they audit their practice, keep up-to-date with current guidance, and how they safeguard the patients in their care.
77. Appendices 10 – 13 provide useful websites and other helpful sources of information for nurse independent prescribers. Pharmacists (see appendix 6) are also a useful source of advice for all prescribers.

Good Practice and Ethical Issues

Good Practice, and Ethical issues for all Nurse Independent Prescribers

Informing patients

78. Nurse independent prescribers must ensure that patients are aware that they are being treated by a non-medical practitioner and of the scope and limits of their prescribing. So there may be circumstances where the patient has to be referred on to another healthcare professional to access other aspects of their care.
79. Nurse independent prescribers must observe the NMC (2006) Practice Standard on 'consent'.²⁴ See Practice Standard 5.

Responsibility for prescribing decisions

80. A nurse independent prescriber can only order a medicine for a patient whom s/he has assessed for care. In primary care, a nurse should only write prescriptions on a prescription pad bearing her/his own unique Prescribing Code and NMC registration number.
81. In the absence of the patient's original nurse prescriber, another nurse prescriber may issue a repeat prescription or order repeat doses following an assessment of need, and taking into consideration continuity of care. Accountability for the prescription rests with the nurse who has issued the prescription or orders the drugs, on each occasion.
82. The NMC (2006)²⁵ provides useful guidance on repeat prescribing (see Practice Standard 19), and on remote prescribing via telephone, email, fax, video link or a website (see Practice Standard 20).
83. Nurse prescribers are professionally accountable for prescribing decisions including actions and omissions and cannot delegate this accountability to any other person (NMC) 2006.²⁶ See Practice Standard 2. If a nurse prescriber moves to another area of practice s/he must consider requirements of the new role and only ever prescribe within her/his level of experience and competence.

Prescribing for self, family and friends

84. Nurse independent prescribers must not prescribe any medicine for themselves. Neither should they prescribe a drug for anyone with whom they have a close personal or emotional relationship, other than in an exceptional circumstance. See NMC (2006)²⁷ Practice Standard 11, and NMC²⁸ (2002), Clause 2.3.

24 NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

25 NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

26 NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

27 NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

28 NMC (2002) Code of Professional Conduct: standards for conduct, performance and ethics. London: NMC.

Stock items

85. 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 indirect reimbursement of practice expenses (see also paragraph 117).

Gifts and benefits

86. The advertising and promotion of medicines is strictly regulated under the Medicines (Advertising) Regulations 1994, and it is important that nurse independent prescribers, and indeed all health professionals, make their choice of medicinal product for their patients on the basis of evidence, clinical suitability and cost effectiveness alone.
87. Nurse independent prescribers must maintain a 'register of interests' within their personal portfolio and produce this on request if required for audit purposes. Local policies on maintaining a register of interests should also be adhered to.
88. As part of the promotion of a medicine or medicines, suppliers may provide inexpensive gifts and benefits, for example pens, diaries or mouse mats. Personal gifts are prohibited, and it is an offence to solicit or accept a prohibited gift or inducement. Companies may also offer hospitality at a professional or scientific meeting or at meetings held to promote medicines, but such hospitality should be reasonable in level and subordinate to the main purpose of the meeting. NHS organisations should have local policies for working with the pharmaceutical industry which cover gifts and benefits, as well as, for example, access to prescribers and sponsorship. Prescribers should familiarise themselves with these policies and are expected to abide by them.
89. The Medicines and Healthcare products Regulatory Agency (MHRA) is responsible for enforcing the legislation on advertising and promotion of medicines. Any complaints about promotional practices should be referred to the MHRA or to the industry self-regulatory body, the Prescription Medicines Code of Practice Authority.

Guidance on Controlled Drugs

90. For guidelines on the prescription of Controlled Drugs, nurse independent prescribers should see Appendix 9 and refer to:
- NMC (2006)²⁹ published guidance on prescribing controlled drugs. See Practice Standard 16
 - 'A guide to good practice in the management of controlled drugs in primary care' – published by the National Prescribing Centre. See: www.npc.co.uk

²⁹ NMC (2006) Standards of Proficiency for nurse and midwife prescribers London: NMC

- Department of Health guidance available at: www.dh.gov.uk
- The legal requirements for prescriptions for Schedule 2 and 3 Controlled Drugs summarised in the British National Formulary
- Scottish Executive Health Department Guidance HDL (2006) 27 available at: www.show.scot.nhs.uk

Patient Records

Patient records

Access and updating

91. All health professionals are required to keep accurate, legible, unambiguous and contemporaneous records of a patient's care. There is no single model or template for a patient record. For guidance, nursing staff should refer to the standards published by the NMC.³⁰
92. A good record is one that provides in a timely manner all professionals involved in a patient's treatment, with the information necessary for them to care safely and effectively for that patient. It is a necessary way of promoting communication within the healthcare team and between practitioners and their patients/clients. Good record keeping is, therefore, both the product of effective team working and a prerequisite for promoting safe and effective care for patients.
93. All nurses are required to keep accurate, comprehensive, contemporaneous records which are accessible by all members of a prescribing team (effective policies must be in place locally to enable this to happen). The principles underlying record keeping, for nurses are detailed in national guidelines for records and record keeping (NMC 2004).³¹ Specifically in relation to prescribing, nurses should refer to NMC (2006),³² Practice Standard 7.
94. In supplementary prescribing, the doctor/dentist and supplementary prescribers must share access to, consult and, wherever possible, use the same common patient/client record (see paras 29 – 31).
95. Best practice suggests that the details of any prescription, together with other details of the consultation with the patient, should be entered into the shared patient record immediately, or as soon as possible after the consultation. Only in very exceptional circumstances (e.g. the intervention of a weekend or public holiday) should this period exceed 48 hours from the time of writing the prescription. This information should also be entered at the same time onto the patient record and onto the nursing patient record (where a separate nursing record exists). Where nurse independent prescribers are working in paperless offices and clinics, and there are no paper records, the electronic data must be entered to comply with the aforementioned good practice. In hospital settings, details of every prescription may not be entered separately in hospital medical records but an individual prescription chart is eventually filed in the patient's notes.

30 NMC (2004) Guidelines for records and record keeping. London: NMC

31 NMC (2004) Guidelines for records and record keeping. London: NMC

32 NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

96. Where practicable, in both hospital and community settings, electronic records should be used, and prescriptions should be generated via these systems. Nurse independent prescribers may prescribe via computer-generated prescriptions provided the necessary software is available. A visible audit trail of prescribing actions must be maintained however and an existing prescriber's details must never be tampered with. Prescriptions should always be signed immediately, and prescriptions must never be written or printed off and signed in advance, and then stored for future use. See NMC (2006)³³ Practice Standard 12.
97. Appendix 5 gives guidance on prescription form completion. It is recommended that any prescription record indicates clearly:
- The date of the prescription
 - The name of the prescriber (together with the fact that they are acting as a nurse independent prescriber)
 - The name of the item prescribed, together with the quantity (or dose, frequency and treatment duration).
98. To aid the safe administration of medicinal preparations the record should include: the name of the item prescribed, the strength (if any) of the preparation, the dosing schedule and route of administration, e.g. 'paracetamol oral suspension 120mg/5mls to be taken every four hours by mouth as required for pain, maximum of 20mls in any 24 hours'.
99. In the case of topical medicines the name of the prescribed item, the strength (if any), the quantity to be applied and the frequency of the application should be indicated. For dressings and appliances, details of how they are to be applied and how frequently changed, are useful. It is recommended that any advice given on General Sale List (GSL), (also known as 'over the counter') items be recorded.

Clinical Management Plans

100. As referred to in paragraph 31, clinical management plans may still be used by nurse independent prescribers as the most appropriate mechanism for prescribing. The NMC (2006) Practice Standard 8 should be followed in such situations, and the latest guidance issued by the Scottish Executive on 'Supplementary Prescribing for Nurses'.

³³ NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

Adverse Drug Reaction Reporting

Adverse Drug Reaction Reporting: how to report a suspected adverse reaction to a medicine prescribed by a nurse

MHRA/CHM Yellow Card Scheme

101. The Yellow Card Scheme is a voluntary scheme through which healthcare professionals notify the Medicines and Healthcare products Regulatory Agency (MHRA)/Commission on Human Medicines (CHM) of suspected adverse drug reactions. The MHRA/CHM encourage the reporting of all suspected adverse drug reactions to newly licensed medicines that are under intensive monitoring/surveillance (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, including herbal medicines. Serious reactions include those that are fatal, life-threatening, disabling, incapacitating or which result in or prolong hospitalisation and/or are medically significant.
102. The 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 at: www.yellowcard.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 BNF).
103. Patients, parents, carers, etc. can also report suspected adverse drug reactions using the above methods. There is also a freephone number, 0808 100 3352, that can be used.
104. The bulletin 'Current Problems in Pharmacovigilance', issued by the MHRA/CHM, contains advice and information on drug safety issues. All prescribers are encouraged to routinely consult the bulletin and keep up to date with new information about safe use of medicines. Copies are on the MHRA's website, which can be found on: www.mhra.gov.uk

The role of NHS Quality Improvement Scotland

105. Drug alerts are issued directly to the NHS by the Chief Pharmaceutical Officer. Alerts issued by the National Patient Safety Agency (which covers England and Wales) are issued in Scotland by NHS Quality Improvement Scotland (NHS QIS). Any follow up of NHS Boards' response to recommendations in alerts would be carried out by NHS QIS as part of their patient safety work programme. Each local health system should have processes for circulation of drug alerts and hazard warnings to nurse independent prescribers, and a system for reporting medication errors and learning lessons from mistakes to ensure patient safety and good nursing practice. As detailed in paragraphs 70–75, clinical governance systems should be in place for nurse prescribing and related activities, and risk management plans put in place.

Legal and Clinical Liability

Legal and Clinical Liability

Liability of the prescriber and professional indemnity

106. Prescribers are accountable for all aspects of their prescribing decisions NMC (2006)³⁴ – Practice Standard 2. They should therefore only prescribe those medicines they know are effective for the patient and the condition being treated. They must be able to recognise and deal with pressures (e.g. from pharmaceutical industry, patients or colleagues) that might result in inappropriate prescribing.
107. The NMC recommends that every nurse prescriber should ensure s/he has professional indemnity, by means of a professional organisation or trade union body. Prescribers must also be aware of the level of indemnity insurance offered by their insurer to determine whether it is sufficient. See clause 9, NMC (2004) Code of Professional Conduct.³⁵

Liability of employer

108. 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 independent 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 (2004) Code of Professional Conduct (see above).

34 NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

35 NMC (2004) Code of Professional Conduct: standards for conduct, performance and ethics. London: NMC.

Prescribing

Prescribing

For a definition of **independent prescribing** refer to paragraph 20

109. The terms 'prescribe', 'supply' and 'administer' are often used imprecisely and with overlap of meaning. The definitions used in the Crown Report³⁶ may be helpful:

Prescribe: in the strict legal sense, as used in the Medicines Act: (i) to order in writing the supply of a prescription only medicine for a named patient; but commonly used in the extended sense of: (ii) to authorise by means of an NHS prescription the supply of any medicine (not just a prescription only medicine) at public expense; and occasionally: (iii) to advise a patient on suitable care or medication (including medicine which may be purchased over the counter).

Supply: to provide a medicine directly to a patient or carer for administration.

Administer: to give a medicine either by introduction into the body, whether by direct contact with the body or not (e.g. orally or by injection), or by external application (e.g. application of an impregnated dressing).

Prescribing and administration

110. Nurse prescribers must ensure separation of prescribing and administering activities wherever possible. See Practice Standard 9.³⁷
111. In exceptional circumstances, where nurse independent prescribers are involved in both prescribing and administering a patient/client's controlled drug, a second suitably competent person should be involved in checking the accuracy of the medication provided.

³⁶ Crown J (1999) Review of prescribing, supply and administration of medicines. London: DOH.

³⁷ NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

Dispensing

Dispensing

Dispensing means: to label from stock and supply a clinically appropriate medicine to a patient/client/carer, usually against a written prescription, for self-administration or administration by another professional, and to advise on safe and effective use.³⁸

Supply is defined above. There is no legal distinction between 'dispense' and 'supply' although there are considerable differences in practice. The act of dispensing includes supply and also encompasses a number of other functions (e.g. checking the validity of the prescription, the appropriateness of the medicine for an individual patient, assembly of the product). In common usage 'dispense' is usually reserved to the activity of pharmacists and dispensing doctors.³⁹

Nurses required to dispense in primary care

112. As stated within the NMC (2004)⁴⁰ Guidelines for the Administration of Medicines, 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.

The NMC (2006)⁴¹ also provides guidance on dispensing. It states that 'dispensing is part of the remit of the pharmacy profession who undertake a clinical screen of prescriptions prior to the dispensing process by trained technicians and a final accuracy check either by a pharmacist or higher level pharmacy technician'.

113. Whilst there is no legal bar to nurse/midwife dispensing there must be in place a local policy agreed to endorse the registrant's actions.⁴² The recipient of the medication will expect the same level of practice from a nurse or midwife as they would from a pharmacist.
114. As a registrant the nurse is accountable for her/his actions and should understand the medication s/he is dispensing, its therapeutic effect, correct dosage, side effects and contra-indications. The registrant should be able to inform the patient what they should expect when taking the medication and to whom any adverse reaction should be reported. Nurses should only dispense medication if they feel competent to do so, and in the knowledge that they are accountable for their actions. A record should be kept of the dispensing practice and, to comply with clinical governance, an audit trail should be present and visible. The same principles apply for all drugs whether they are prescription only medicines or pharmacy-level medicines.
115. The NMC recommends that nurses ensure they are covered for vicarious liability and seek appropriate indemnity insurance for this practice.

38 NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

39 Crown J (1999) Review of prescribing, supply and administration of medicines. London: DOH.

40 NMC (2004) Guidelines for the Administration of Medicines. London: NMC.

41 NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

42 NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

Prescribing and Dispensing

116. Nurse prescribers must ensure separation of prescribing and dispensing whenever possible, including within dispensing practices (see below). In exceptional circumstances, where nurses are involved in both prescribing and dispensing a patient/client's medication, a second suitably competent person should be involved in checking the accuracy of the medication provided. See Practice Standard 10.⁴³
117. Where a stock supply of medication has been labelled and dispensed by a pharmacist and is then supplied by a nurse/midwife in an 'out-of-hours' or family planning situation this is not dispensing, but supplying.

Nurse prescribing in dispensing practices in primary care

118. Where a GP practice is a dispensing practice, prescriptions from nurse independent prescribers can be dispensed by the practice but only for the dispensing patients of that practice. Dispensing doctors cannot dispense prescriptions written by nurse and pharmacist independent prescribers for patients of other practices.
119. When submitting prescriptions to the PSD, dispensing practices should include them with their GP10 form count on their GP34 declaration and sort them as per existing instructions.
120. Reimbursement for nurse and midwife prescriptions can be claimed by dispensing doctors and payment for the prescriptions submitted will be made to the practice partnership.
121. Pharmacists are a useful source of help and advice to any prescriber, and the dispensing pharmacist will need to be sure that the prescriber has qualified as a nurse independent prescriber (see Appendix 6).

Dispensing by appliance contractors

122. When a nurse becomes aware that the patient intends to have a prescription dispensed by an appliance contractor, s/he must ensure that the prescription form does not also include medicinal preparations (appliance contractors cannot dispense medicinal preparations). Appliance contractors should follow the instructions on the Prescription Invoice – Form GP34B – when sorting prescription forms prior to sending them to the Practitioner Services for pricing. N.B. appliances should be on a separate prescription form to other medications.

43 NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

Urgent dispensing

123. Occasionally a nurse prescription may need to be dispensed out of normal pharmacy opening hours. NHS Boards hold lists of pharmacies able to dispense in an emergency. Alternatively, information could be obtained through the NHS Board out-of-hours Centre or NHS 24. Also see paras 81 – 82.

Dispensing of items in England, Wales and Northern Ireland

124. Prescriptions written by nurse independent prescribers in Scotland will only be dispensable by pharmacists in England, Wales and Northern Ireland when the Administrations amend their pharmaceutical regulations, to permit them to be dispensed at NHS expense.

Dispensing items against nurse independent prescriber's prescription in hospital pharmacies

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

Monitoring

126. Hospital employers will find it beneficial to collect and analyse prescribing data on nurse independent prescribers alongside the routine monitoring of prescribing by doctors.
127. The route for accessing prescribing data for non-medical prescribers depends on where their prescribing costs are allocated.
128. See also paragraphs 75 and 105 and appendix 7. They detail the monitoring arrangements that employing organisations need to put in place to ensure safe prescribing and administering of medicines.
129. Local policies need to be in place to endorse dispensing and supply activities by nurses, and audit trails must be available (see para 114).
130. Clinical Governance systems will ensure independent prescribing is practised safely and in patients' interests.

Appendices

APPENDIX 1:

NOTIFICATION OF NURSE PRESCRIBER DETAILS TO EMPLOYER IN LOCAL NHS BOARD

1. Nurses will have 'licence as a prescriber' once they have successfully completed an NMC approved programme, and recorded this in the NMC's register. See NMC (2006)⁴⁴ Practice Standard 1.
2. Once the nurse or midwife has successfully completed the prescriber preparation, the NMC will be notified by the Higher Education Institution. The individual's entry on the NMC professional register will be annotated to indicate that she/he has qualified as a nurse independent prescriber. A nurse or midwife cannot legally prescribe until this annotation has been made. This will be a different annotation to that used for a community practitioner nurse prescriber. The NMC Voice Bank telephone line will confirm to any enquirer whether or not a nurse is eligible to prescribe. A password is required by employers to check eligibility and enquiries can be made by email.

NMC Voice Bank Enquiries

3. Callers will need to state the nurse prescriber's PIN and date of birth otherwise they will have to speak to a manual operator on the system.

The telephone number is 020 7631 3200

The pass number is: 6390; The code number is 20

V100, DN/HV prescriber, is now annotated as a Community Practitioner Nurse Prescriber; V200 or V300, Extended Formulary/Supplementary Prescriber, are now Nurse Independent Prescribers. Also see paras 28 – 30 for different categories of Nurse Prescriber.

⁴⁴ NMC (2006) Standards of Proficiency for nurse and midwife prescribers. London: NMC

APPENDIX 2:

ACTIONS FOR EMPLOYER: NOTIFICATION OF QUALIFICATION TO PRESCRIBE

1. The Higher Education Institution will advise the individual's employer of successful or unsuccessful completion of the prescribing programme. For nurses successfully completing the programme, the employer is then advised to take the following actions.
2. There is no requirement for HIG/ISD to be informed of hospital-based nurse prescribers. The prescribing lead nurse(s) for each NHS Board is/are responsible for informing the HIG/ISD of GP practice prescribers using the attached form, ISD (P) 1. HIG will continue in their existing role of assigning prescribers codes to nurse prescribers.
3. Registration and similar notification arrangements need to be set up by the prescribing lead(s) for hospital-based nurse independent prescribers.
4. The nurse details to be provided on the proforma include:
 - Name
 - NMC number
 - Qualifications (Community Practitioner Nurse Prescriber or Nurse Independent/Supplementary Prescriber)
 - Practice/Directorate/Department/Therapeutic area
 - Employer details
5. The prescribing lead(s) notifying HIG/ISD of new nurse prescribers who work across more than one practice will be required to provide details of the practice within which the nurse is expected to issue the majority of their prescriptions (i.e. their 'main prescribing practice'). These nurses will receive one prescription pad pre-printed with the prescriber code for this practice and one prescription pad part-printed with the nurse's name, NMC number and contact telephone number. Prescribers will need to write the appropriate nurse prescriber code on each prescription form for any additional practice.
6. Where the nurse prescriber works in a primary care setting as well as in secondary care, the above arrangements need to be followed. Similar arrangements need to be set up by the prescribing lead(s) within hospital-based settings for hospital-based prescribers.

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: eVADIS Team, Healthcare Information Group, Area 114c, Gyle Square, 1 South Gyle Crescent, Edinburgh EH12 9EB
 or e-mail to : evadis@isd.csa.scot.nhs.uk

From: NHS Board Telephone

Please tick appropriate box

- | | |
|--------------------------|---|
| <input type="checkbox"/> | New Nurse Prescriber |
| <input type="checkbox"/> | Change of name or PIN (NMC) |
| <input type="checkbox"/> | Change of qualification to prescribe |
| <input type="checkbox"/> | NHS employment ends/No longer prescribing |
| <input type="checkbox"/> | Change of practice (please indicate which) |
| <input type="checkbox"/> | Additional practice (please indicate which) |

- (Complete sections A, B, C and D)**
(Complete sections A and B)
(Complete sections A and B)
(Complete sections A, B, C and D)
(Complete sections A, B, C and D)
(Complete sections A, B, C and D)

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

--

SECTION A:

Nurse (Delete as applicable)

- | | |
|---|---|
| 1 | Surname |
| 2 | Forename and Initials |
| 3 | Job Title |
| 4 | PIN (NMC) |
| 5 | Unique Prescriber Code |
| 6 | Formulary: (please indicate which) |
| | <ul style="list-style-type: none"> • Community Practitioner Nurse Prescriber • Nurse Independent/Supplementary Prescriber |
| 7 | Prescriber's contact telephone number: |

Details prior to change Details of change

SECTION B: Practice Details

- | | |
|---|---|
| 1 | Practice Code |
| 2 | Practitioner/Senior GP name |
| 3 | Practice Address. (Prescription stationery will be forwarded to this address by the NHS Board.) |
| 4 | Is this the Prescriber's main prescribing practice?* |

Details prior to change Details of change

	Yes/No (Delete as applicable)

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

Please continue overleaf

SECTION C: NHS Employer Details

		Details prior to change	Details of change
1	Health Board Name		
2	Health Board Address		

SECTION D: Prescriber Employment Details

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

SECTION E: Details of person notifying registration:

Please print name:

Job title:

Contact telephone number:

Contact address:

.....

.....

.....

Signature

Date

HIG use only	Prescriber code:	Date issued:
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APPENDIX 3:

ACTIONS FOR EMPLOYER: NOTIFICATION OF CHANGE OF NURSE PRESCRIBER DETAILS

1. In primary care, the prescribing lead(s) should notify HIG/ISD of changes of circumstances or personal details of nurse prescribers using the form in Appendix 2. Each nurse prescriber has an individual responsibility to inform their local prescribing lead nurse of any changes in personal details. If a nurse prescriber is no longer carrying out prescribing duties (for example, because s/he has left employment or been suspended from the register of nurses or had her/his approval as a prescriber withdrawn for some reason), the prescribing lead nurse(s) should inform HIG/ISD as soon as possible.
2. This requirement highlights the need for clear channels of communication, particularly between community practitioner nurse prescribers, nurse independent prescribers and employers. It is the responsibility of the nurse's employer:
 - to ensure that no further prescription pads are ordered for a nurse who has left employment or who has been suspended from prescribing duties;
 - to recover, record and securely destroy all unused prescription forms issued to that nurse relating to that employment.

The prescribing lead nurse(s) should annotate their lists of nurse prescribers with the reasons for any changes, to ensure that an up-to-date record exists. This can be maintained using an electronic database.

3. Similar notification arrangements need to be set up by the prescribing lead(s) for hospital-based nurse prescribers.

APPENDIX 4

OBTAINING PRESCRIPTION FORMS FOR NURSE PRESCRIBERS

1. Community-based nurse prescribers must be registered with HIG/ISD before prescription forms can be issued. Early notification of such details is important so that appropriately qualified nurses can begin utilising their new skills.
2. **Ordering Stationery:**
Ordering GP10N Stationery
On receipt of form ISD (P) 1 (see Appendix 2) from HIG, each nurse prescriber will be issued with a unique prescriber code, and the lead nurse prescriber will order a supply of stationery for the community practitioner nurse prescriber and/or the nurse independent prescriber using form PSD 1 (see attached), to be sent to: Practitioner Services, Area 233C, Gyle Square, 1 South Gyle Crescent, Edinburgh EH12 9EB.

Ordering HBPN Stationery
The Chief Pharmacist or prescribing lead for hospital-based nurse prescribers should order HBPN forms (on PSD HBPN Order forms, see attached); they will be supplied, pre-printed, with nurse and hospital details.
3. Prescriptions are normally sent to the address of the person who orders them (an alternative address can be specified). Checks are made to ensure that prescriptions are only supplied to NHS organisations.
4. **Non-NHS nurses** cannot issue a NHS prescription, i.e. one written on a form GP10N or HBPN for dispensing in an NHS community pharmacy, unless the organisation they work for has an arrangement or 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 GP10N or HBPN prescription forms and obtain prescribers' codes via HIG in the usual way.

PRESCRIPTION FORMS FOR NURSES AND MIDWIVES IN PRIMARY CARE

5. Existing nurse prescribers will already have supplies of GP10N forms. These will be retained for existing Extended Formulary/Supplementary Prescribers but will gradually be updated and replaced, so that through 2006, nurse prescribers will be using prescription forms pre-printed with the nurse's name, NMC number, practice address and contact telephone number. The forms will also be annotated nurse independent prescriber.
6. GP10N prescription forms will also be pre-printed with the nurse prescriber code. Nurses directly employed in primary care working across more than one GP practice and using multiple prescriber codes will be issued with a prescription pad pre-printed with the prescriber code for the 'main prescribing practice', i.e. the practice within which the nurse issues the majority of their prescriptions. For the additional practices they will be issued part-printed with the nurse's name, NMC number and contact telephone number. Prescribers will need to write the appropriate nurse prescriber code on each prescription form.

PRESCRIBING FORMS FOR HOSPITAL-BASED NURSES AND MIDWIVES

7. Nurse prescribers prescribing for hospital in or out-patients may use three methods to prescribe:
 - Ward order – to be used for inpatients and discharge supplies only. A prescription charge is not levied on inpatients.
 - Internal hospital prescription form – to be used for out-patients but only in cases where the hospital pharmacy will dispense the prescription. A prescription charge may be payable, unless the patient is exempt from prescription charges. For this reason, these types of form often resemble a GP10N prescription form **(N.B. internal hospital forms cannot be accepted for dispensing by community pharmacies)**.
 - HBPN prescription form, **where the prescription will be dispensed by a community pharmacist**. (Note: nurse employers should establish a local policy on the use of HBPN prescription forms.) These forms should be ordered by the Chief Pharmacist/lead nurse, as described above.

PSD 1 GP10N Order Form

COMMUNITY-BASED NURSE PRESCRIBERS PRESCRIPTION PAD ORDER FORM

To: Practitioner Services 2nd Floor, Gyle Square, 1 South Gyle Crescent, Edinburgh EH12 9EB
Tel: 0131 275 6979 Fax: 0131 275 7266

From: NHS Board Telephone

TO BE COMPLETED BY PRESCRIBING LEAD NURSE

Please tick appropriate box

**Community Practitioner
Nurse Prescriber**

Unique Prescriber Code

NMC No.

**Nurse Independent/
Supplementary Prescriber**

Surname: Initial:

Contact Telephone Number: Part Printed Pads

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

Is this a change of Main Practice Address? YES/NO Is this an additional Practice? YES/NO

(Pad will be forwarded to Main Practice Address)

Main Practice Address

.....

.....

Postcode

Address for pad delivery, if no main practice

YES

NO

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

If yes, how many practices?

Address for delivery (stores department):

.....

.....

Postcode:

NHS Board Details

Signed:(Lead Nurse)

Date:

Print Name:

Telephone Number:

PSD HBPN Order Form

HOSPITAL-BASED NURSE PRESCRIBER'S PRESCRIPTION PAD ORDER FORM

To: Practitioner Services 2nd Floor, Gyle Square, 1 South Gyle Crescent, Edinburgh EH12 9EB
Tel: 0131 275 6979 Fax: 0131 275 7266

From: NHS Board Telephone

TO BE COMPLETED BY CHIEF PHARMACIST/PRESCRIBING LEAD NURSE

Please tick appropriate box

**Community Practitioner
Nurse Prescriber**

Hospital/Clinic Code

NMC No.

**Nurse Independent/
Supplementary Prescriber**

Surname: **Initial:**

Contact Telephone Number:

Hospital Name and Address (Pad will be forwarded here)

Address for pad delivery

.....
.....

Postcode

Address for delivery (stores/pharmacy department):

NHS Board Details

.....
.....

Postcode:

Signed:(Lead Nurse) **Date:**

Print Name: **Telephone Number:**

GUIDANCE NOTES

All prescription pads will be delivered directly to the NHS board at the address specified on this form prior to the NHS Board distribution to the nurse prescriber.

Number of Pads

A minimum of 5 pads will be automatically ordered for each nurse on completion of this form.

Hospital-Based Prescribing Nurses (HBPN)

Only the nurse's name and NMC number required. All pads will be forwarded to the hospital directly.

GP10(N)

All sections must be completed. Prescription pads will be delivered to the NHS board stores department before being forwarded to the nurse prescriber. If the nurse prescriber does not have a main practice, a GP practice address must be provided for prescription pads to be forwarded to.

APPENDIX 5

HOW TO COMPLETE THE PRESCRIPTION FORM

1. Detailed advice on prescription writing is contained in the British National Formulary (BNF).
2. The nurse prescriber should complete all the details on the front of the prescription form by writing clearly and legibly using an indelible pen (preferably black). The details required are:
 - the patient's title, forename, surname and address (including postcode)
 - age – N.B. 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
 - CHI number, when possible
 - nurse prescribers should use the product description as listed in the BNF
 - for prescribing in primary care, the prescription should contain the name of the prescribed item, formulation, strength (if any) dosage and frequency, and quantity to be dispensed. The quantity prescribed should be appropriate to the patient's treatment needs, bearing in mind the need to avoid waste. Some medicines are only available in patient packs (or multiples thereof)^{45 46} and special containers⁴⁷ and the quantity contained should be prescribed, provided this is clinically and economically appropriate. The quantity should be specified for solid preparations as number of dose-units (number of tablets, capsules, lozenges, patches, etc.), for liquid measures in millilitres (mL or ml), for topical preparations by mass (grams, g) or volume (millilitres, ml). 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(s) of treatment can be given in place of quantity to be dispensed. Current best practice requires quantity to be clear on the prescription form.

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

46 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.

47 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 in-patients should contain the name of the prescribed item, formulation, strength (if any), dosage and frequency. Where a defined length of treatment is required this should be stated. For outpatients and discharge prescriptions, the requirements are the same as those for primary/community care, whilst recognising local policies for example on the length of treatment provided for outpatients and patients who were being discharged
 - the names of medicines should be written clearly using approved generic titles (where available) as specified throughout the BNF and should not be abbreviated. The only exception to this rule is for the prescribing of some dressings and appliances, and of compound or modified release medicines which have no approved non-proprietary name
 - directions, if for use or application by the patient or carer, which should be in English and not abbreviated
 - where there is more than one item on a form, a line should be inserted between each item for clarity
 - unused space in the prescription area of the form should be blocked out with, for example, a diagonal line (to prevent subsequent fraudulent addition of extra items)
 - prescriber's signature and date
 - nurses should ensure the appropriate prescriber code is entered on the prescription form if this has not been pre-printed.
3. Nurses will need to ensure that the prescription is cost-effective and meets the clinical needs of the patient. Local formularies may help here. Patients requiring long-term treatments should have their clinical management and medical product needs regularly assessed and prescriptions issued should reflect assessed need. For patients with enduring conditions that require continuing medication, dressings or appliances, nurses will need to balance patient convenience with the need to avoid waste of NHS resources and of excessive quantities of medicines in the patient's home. Only sufficient supplies should be prescribed to enable the fulfilment of the care plan, normally up to the re-evaluation date. Current best practice indicates that regular prescriptions should be issued for up to 28 days.
4. Items that require a doctor's signature should not be entered on a nurse prescription even if the doctor countersigns them. A GP prescription must be used at all times when the GP's signature is required.

APPENDIX 6

ROLE OF THE PHARMACIST – ADVICE ON MEDICINES

1. Pharmacists are a useful source of help and advice to any prescriber, particularly on matters of pharmacology, drug usage and product selection. They will also know the costs, availability and pack sizes of prescribed items.
2. To enable pharmacists to check whether a nurse prescription handed in for dispensing is bona fide, all NHSScotland employers should keep a list of all nurse prescribers employed by them and the terms by which the nurse can prescribe. It is also recommended that a copy of the nurse's or midwife's signature is held by the employing authority and individuals should be prepared to provide specimen signatures to pharmacists, should that be required.
3. Community pharmacists will expect to see primary care nurse prescriptions on a GP10N; hospital-based nurse prescriptions on an HBPN. Nurses must not use other types of prescription form.
4. Nurse or midwife prescribers should be aware that pharmacists have legal and ethical obligations which mean they may need to contact prescribers – sometimes urgently – to confirm an aspect of the prescription, return it for amendment or even to refrain from dispensing it (for example if the prescription appears unsafe, inappropriate, or contains items which a nurse is not permitted to prescribe). An up-to-date contact telephone number should be included (in the address box) on all prescriptions.

VERIFICATION OF PRESCRIBING STATUS

1. The dispensing pharmacist will need to be sure that the prescriber has qualified as a nurse prescriber.
2. The prescription form will indicate the category of nurse prescriber (see paragraphs 28 – 31). The dispensing pharmacist will, of course, need to use her/his professional judgement, as for doctor's prescriptions, to assess whether a prescription is appropriate for a particular patient.
3. In the case of nurses, most enquiries from dispensing pharmacists will be resolved by telephoning the prescriber, or the prescriber's employer (see above).
4. Anyone can check the prescribing status of a nurse by accessing the NMC website www.nmc-uk.org and searching the Register. This can be done by simply entering a name and/or NMC registration number and will confirm if someone has live registration and what type of prescriber they are.

APPENDIX 7

SECURITY AND SAFE HANDLING OF PRESCRIPTION FORMS

1. The security of nurse prescription forms is the responsibility of both the employing organisation and the nurse prescriber. It is advisable to hold only minimal stocks of the prescription forms. This reduces the number lost if there is a theft or break-in, and also helps keep prescription forms up to date.
2. The nurse employer should record the serial numbers of prescriptions received and subsequently issued to individual prescribers, surgeries, clinics, etc. For this type of 'stock control' record, there is no need to record every number in each pad – just the first and last numbers of each pad. Note that the prescription serial number is the first 10 numbers (these run in sequence), the final digit is a check digit (and does not run in sequence).
3. Local policy should be established regarding monitoring the use of prescription forms to deter the creation of fraudulent prescriptions. For example, if practicable, a Practice or Prescribing Manager may undertake, from time to time, a reconciliation between the number of prescriptions written during a session with the number of forms used by individual prescribers. Or more detailed records, such as a log of each patient prescribed for and the serial number of the prescription issued to them may be required.
4. The nurse prescriber should also keep records of the serial numbers of prescriptions issued to them. The first and last serial numbers of pads should be recorded. It is also good practice to record the number of the first remaining prescription form of an in-use pad at the end of the working day. Such steps will help to identify any prescriptions that are either lost or stolen overnight.
5. Blank prescription forms should not be pre-signed, to reduce the risk of misuse should they fall into the wrong hands. In addition, prescription forms should only be produced when needed, and never left unattended. Prescription forms should not be left on the desk but rather placed in a locked drawer. When out visiting, it is advisable for nurses to keep prescription pads in their bags – they should never be left in the car.
6. Best practice recommends that where possible, all unused forms should be returned to stock at the end of the session or day. It is strongly recommended that this happens in practice. Blank prescription forms should not be left in cars, desks or bags, to help ensure their security. Prescriptions are less likely to be stolen from (locked) secure stationery cupboards than from desks, bags or cars.

APPENDIX 8

LOSS OF PRESCRIPTION FORMS

1. Practitioner Services Division (PSD) should be contacted about prescriptions ordered, but not delivered.
2. Practice-based nurse prescribers should report the loss or theft to the Prescribing Lead as soon as possible after the theft/loss is confirmed, giving details of the approximate number of scripts stolen, their identification numbers, and where and when they were lost or stolen. The nurse should inform the GP (where appropriate) as soon as s/he is aware of missing scripts.
3. The GP should ensure that the nurse prescriber has informed the prescribing lead within the NHS Board by telephone, as soon as s/he is aware that any prescription forms have been stolen from the nurse in her/his team.
4. The Prescribing Lead should notify the Fraud Liaison Officer (FLO) at the NHS Board who should notify the local pharmacists and decide upon any necessary action to minimise the abuse of the forms. The FLO should notify the National Services Scotland, Counter Fraud Services who will maintain a database of lost/stolen prescription forms.
5. Following the reported loss of a prescription form the Prescribing Lead will normally tell the prescriber to write and sign all scripts in a particular colour (usually red) for a period of 2 months. The NHS Board will inform all pharmacies in their area and adjacent NHS Boards of the name and address of the prescriber concerned, the approximate number of scripts stolen and the period within which the prescriber will write in a specific colour. This will normally be put in writing within 24 hours with the exception of weekends.
6. In the event of a loss or suspected theft from a hospital-based nurse prescriber, s/he should report this immediately to whoever issued the prescription forms (normally the hospital pharmacy) and the local fraud specialist or finance director of the Board. The nurse 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 of theft of prescription forms – this may include writing and signing all scripts in a particular colour (usually red) for a period of 2 months.

7. It is the responsibility of the employer to ensure that prescription pads are retrieved from nurses or midwives who leave their employment for whatever reason. Prescription pads should be securely destroyed, e.g. by shredding and treated as confidential waste. It is advisable to record first and last serial numbers of the pads destroyed. Failure to recover prescription forms may potentially incur a cost, as any item prescribed on forms after nurses have left employment would still be charged to the appropriate budget.

APPENDIX 9

CONTROLLED DRUGS

Nurse independent prescribers can prescribe any licensed medicine for any medical condition, including some controlled drugs. They are able to prescribe the following list of Controlled Drugs, solely for the medical conditions indicated:

- diamorphine, morphine, diazepam, lorazepam, midazolam, or oxycodone for use in palliative care;
- buprenorphine or fentanyl for transdermal use in palliative care;
- diazepam, lorazepam, midazolam for the treatment of tonic-clonic seizures;
- diamorphine or morphine for pain relief in respect of suspected myocardial infarction, or for relief of acute or severe pain after trauma including in either case post-operative pain relief;
- chlordiazepoxide hydrochloride or diazepam for treatment of initial or acute withdrawal symptoms, caused by the withdrawal of alcohol from persons habituated to it;
- codeine phosphate, dihydrocodeine tartrate or co-phenotrope (no restrictions on medical conditions).

Details of the appropriate route of administration for these Controlled Drugs can be found in the table below:

Substance	Route of administration
Buprenorphine	Transdermal administration in palliative care
Chlordiazepoxide hydrochloride	Oral
Codeine phosphate	Oral
Co-phenotrope	Oral
Diamorphine hydrochloride	Oral or parenteral
Diazepam	Oral, parenteral or rectal
Dihydrocodeine Tartrate	Oral
Fentanyl	Transdermal administration in palliative care
Lorazepam	Oral or parenteral
Midazolam	Parenteral or buccal
Morphine hydrochloride	Rectal
Morphine sulphate	Oral, parenteral or rectal
Oxycodone hydrochloride	Oral or parenteral administration in palliative care

N.B. CHECK WITH THE PHARMACY DIVISION FOR ANY CHANGES TO THIS GUIDANCE

APPENDIX 10

PROVISION OF FORMULARIES AND DRUG TARIFFS FOR NON-MEDICAL PRESCRIBERS

Nurse Independent/Supplementary Prescribers (and Community Practitioner Nurse Prescribers) receive a copy of the **Nurse Prescribers' Formulary for Community Practitioners (NPF)**, which is published every 2 years.

Nurses who are qualified as Nurse Independent/Supplementary Prescribers (formerly Extended Formulary Nurse Prescribers/Supplementary Prescribers) will also receive a 6-monthly copy of the **British National Formulary (BNF)**.

In addition, Nurse Independent/Supplementary Prescribers who work with children should receive a copy of the **BNF for Children (BNFC)**, which is produced annually.

APPENDIX 11

LEGAL CLASSIFICATION OF MEDICINES

There are various legal controls on the retail sale or supply of medicines which are set out in the Medicines Act 1968. Medicines are classified into three categories – Prescription Only (POM), Pharmacy (P) or General Sale List (GSL). Each category is subject to a number of controls. These controls apply to medicines sold or supplied by retail whether they are sold or supplied via internet transactions, by mail order, or any other form of supply. The general rule is that all licensed medicines are P unless otherwise designated.

Prescription Only Medicine (POM):

These medicines may be sold or supplied only from a registered pharmacy and in accordance with a prescription issued by an appropriate practitioner (a doctor, dentist, nurse independent prescriber, pharmacist independent prescriber or supplementary prescriber). Section 58 of the Medicines Act 1968 refers, as amended by Regulation.

Pharmacy (P):

Pharmacy medicines do not require a prescription and may be sold or supplied only in a registered pharmacy by or under the supervision of a pharmacist. The package gives information on dosage. In some cases the size of the pack will designate a substance as POM (e.g. paracetamol). Section 52 of the Medicines Act 1968 refers, as amended by Regulation.

General Sale List:

These drugs are those regarded by the CHM/MHRA which can be sold with reasonable safety without the supervision of a pharmacist, for example in a supermarket. However they can only be sold from lockable premises and in the original manufacturer's packs. Section 53 of the Medicines Act 1968 refers, as amended by Regulation.

Medicines Unlicensed in the UK

Separate and additional national controls apply to the supply of a medicine which is not licensed for marketing within the UK. Such medicines cannot be advertised. In addition, a doctor or dentist (or a nurse or pharmacist supplementary prescriber working under a CMP) can only prescribe the use of an unlicensed medicine where his patient has a special need that a licensed medicine cannot meet or where an appropriate licensed medicine is not available. (In this context, cost is not regarded as a special need.)

APPENDIX 12

USEFUL WEBSITES/RESOURCES

Scottish Executive Health Department: www.scotland.gov.uk/topics/health/nhs-scotland/non-medicalprescribing

Drug Information: www.druginfozone.nhs.uk

European Council for Classical Homeopathy: www.homeopathy-ecch.org

Medicines and Healthcare products Regulatory Agency website contains information about the legal framework governing the prescribing, supply and administration of medicines: www.mhra.gov.uk

Medicines Partnership Programme: www.npc.co.uk/med_partnership/index.htm

National Prescribing Centre: www.npc.co.uk produce useful information including, competency frameworks, guides to practice and resources to help health care professionals understand prescribing matters. They also provide study days and conferences to update practitioners.

Patient group directions: www.nes.scot.nhs.uk/pgds

PRODIGY is an electronic system which provides prescribing advice for GPs. It produces patient information leaflets and lists drugs recommended by PRODIGY and links them to the condition and situation in which they are recommended: www.prodigy.nhs.uk

Royal Pharmaceutical Society of Great Britain: www.rpsgb.org contains information about prescribing and dispensing.

Standards of proficiency for nurse and midwifery prescribers are available on: www.nmc-uk.org These give national standards on education and practice.

Training for Nurse Prescribers. The NMC requirements for training nurse prescribers are available on: www.nmc-uk.org

Training and related information on education and lifelong learning for the NHS workforce in Scotland is available on: www.nes.scot.nhs.uk. NHS Education for Scotland (NES) was established in 2002.

APPENDIX 13

GLOSSARY

Approved Education Institution:

An education institution that has been approved to deliver a NMC approved programme.

Clinical Governance:

Quality assurance activities that ensure predetermined clinical standards that have been set are seen to be maintained by practitioners and are evident within health care settings.

Clinical Management Plan (CMP):

The CMP 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. The clinical management plan is required to include details of the illness or conditions that may be treated, the class or description of medical products that can be prescribed or administered and the circumstances in which the supplementary prescriber should refer to, or seek advice from the independent prescriber. Supplementary prescribers must have access to the same patient health records as the independent prescriber. Since April 2005, nurse supplementary prescribers can prescribe controlled drugs, provided the independent prescriber (doctor/dentist) has agreed to this within the clinical management plan.

Competence:

Relates to the need for the student to demonstrate their 'capability' in certain skill areas to a required standard at a point in time.

Competencies:

Component skills which contribute to being competent and achieving the standards of proficiency for registration. Competencies might include skills arising from learning outcomes or other requirements.

Designated Medical Practitioner (DMP):

Identified named medical practitioner who provides supervision and support to nurse/midwife prescribers, assesses their application of theory to practice and signs off satisfactory completion of the period of learning and assessment in practice.

Dispensing:

To label from stock and supply a clinically appropriate medicine to a patient/client/carer, usually against a written prescription, for self-administration or administration by another professional, and to advise on safe and effective use.

General Sale List Medicine (GSL):

See Appendix 11.

Independent Prescribing:

A prescriber who is legally permitted and qualified to prescribe and takes the responsibility for the clinical assessment of the patient/client, establishing a diagnosis and the clinical management required, as well as the responsibility for prescribing and the appropriateness of any prescribing.

Learning Outcomes:

Developed by programme providers (approved educational institutions and their service partners), and which contribute towards and demonstrate the meeting of all NMC standards of proficiency by the end of the programme. Learning outcomes can be grouped together to form module outcomes and each module can then be assessed individually. Each module builds on the next towards meeting overall professional programme requirements.

Licensed Medication:

The Medicines and Healthcare products Regulatory Agency (MHRA) operates a system of licensing before medicines are marketed (see **marketing authorisation**). However, the Medicines Act allows certain exemptions from licensing which include:

- The manufacture and supply of unlicensed relevant medicinal products for individual patients (commonly known as 'specials')
- The importation and supply of unlicensed relevant medicinal products for individual patients
- Herbal remedies exemption

Marketing Authorisation:

Previously known as a 'product licence'. This normally has to be granted by the MHRA before a medicine can be prescribed or sold. This authorisation, which confirms that medicines have met standards for safety, quality and efficacy, considers all of the activities associated with marketing medicinal products.

Medicines Act Exemptions:

Allow certain groups of healthcare professionals including occupational health schemes and midwives to sell, supply and administer particular items directly to patients/clients. Provided the requirements of any conditions attached to those exemptions are met, a Patient Group Direction is not required.

Nurse Independent Prescribers:

Nurses and midwives who are on the relevant parts of the Nursing and Midwifery Council (NMC) register may train to prescribe any medicine for any medical condition within their competence including some controlled drugs.

Nurse Prescribers Formulary for Community Practitioners (CPF):

The formulary from which nurses who have successfully completed the integrated prescribing component of the SPQ/SCPHN programme, may prescribe independently.

Objective Structured Clinical Examination (OSCE):

The OSCE is an examination that focuses on outcomes that contribute to clinical competence. The student's practice is assessed in a number of simulated clinical scenarios.

Over the Counter Medicine (OTC):

See Appendix 11 (same as General Sale List)

Parts of the Register:

The NMC register, which opened on 1 August 2004, has three parts: nurses, midwives and specialist community public health nurses. A record of prescribing qualifications on the register identifies the registrant as competent to prescribe as a community practitioner nurse prescriber or a nurse independent/supplementary prescriber.

Patient Group Direction (PGD):

A Patient Group Direction is a written instruction for the supply or administration of named medicines to specific groups of patients who may not be individually identified before presenting for treatment. Guidance on the use of PGDs can be found in the NES website. It is vital that anyone involved in the delivery of care within a PGD is aware of the legal requirements. It is not a form of prescribing.

Patient Specific Direction:

Are written instructions from a doctor, dentist or nurse prescriber for a medicine to be supplied and/or administered to a named person. This could be demonstrated by a simple request in the patient/client's notes or an entry on the patient's drug chart

Pharmacy Medicine (P):

See Appendix 11.

Prescription only medicines (POM):

See Appendix 11.

Register of interests:

Prescribers are required to keep a 'register of interests' that could impact on their prescribing practice, such as links with pharmaceutical companies, use of pharmaceutical companies to sponsor events, any gifts received, etc.

Registrants:

Nurses, midwives and specialist community public health nurses currently entered in the NMC register.

Repeat Prescribing:

A partnership between patient/client and prescriber that allows the prescriber to authorise a prescription so it can be repeatedly issued at agreed intervals, without the patient/client having to consult the prescriber at each issue.

Requirements:

These include the rules, standards and principles relating to a programme.

Rules:

Rules are established through legislation and they provide the legal strategic framework from which the NMC develops standards, e.g. Education, Registration and Registration Appeals Rules 2004 (SI 2004/1767). 'Standards' support the rules. Standards are mandatory and gain their authority from the legislation, in this case the order and the Rules.

Specialist Community Public Health Nurse:

A nurse who aims to reduce health inequalities by working with individuals, families, and communities promoting health, preventing ill health and in the protection of health. The emphasis is on partnership working that cuts across disciplinary, professional and organisational boundaries that impact on organised social and political policy to influence the determinants of health and promote the health of whole populations

Specialist Practitioner Qualification:

The Qualification awarded to registrants on successful completion of a programme of preparation leading to specialist practice. Specialist practice is the exercising of higher levels of judgement, discretion and decision making in clinical care.

Stakeholders:

Those who have a major interest in ensuring an effective programme outcome, including programme providers, placement providers, students, mentors, practice teachers, external examiners, external agencies, service users and carers.

Standards:

The NMC is required by the Nursing and Midwifery Order 2001 to establish standards of proficiency to be met by applicants to different parts of the register. The standards are considered to be necessary for safe and effective practice [Article 5(2)(a)]. These are set out within the *Standards of proficiency* for each of the three parts of the register and for the recorded qualification of nurse/midwife prescriber.

Supplementary Prescribing:

A voluntary partnership between an independent prescriber (doctor/dentist) and a supplementary prescriber, to implement an agreed patient/client-specific Clinical Management Plan with the patient's agreement.

Unlicensed Medicines:

This term refers to medicines that are not licensed for any indication or age group (also see appendix 11). Reasons why a drug may not be licensed include:

- The drug is undergoing a clinical trial, has been imported, or has been prepared extemporaneously or under a special manufacturing licence
- The product is not a medicine but is being used to treat a rare condition

V100, V200, V300:

Codes used by Approved Education Institutions to notify a registrant's successful completion of a programme to the NMC

Video Consultation:

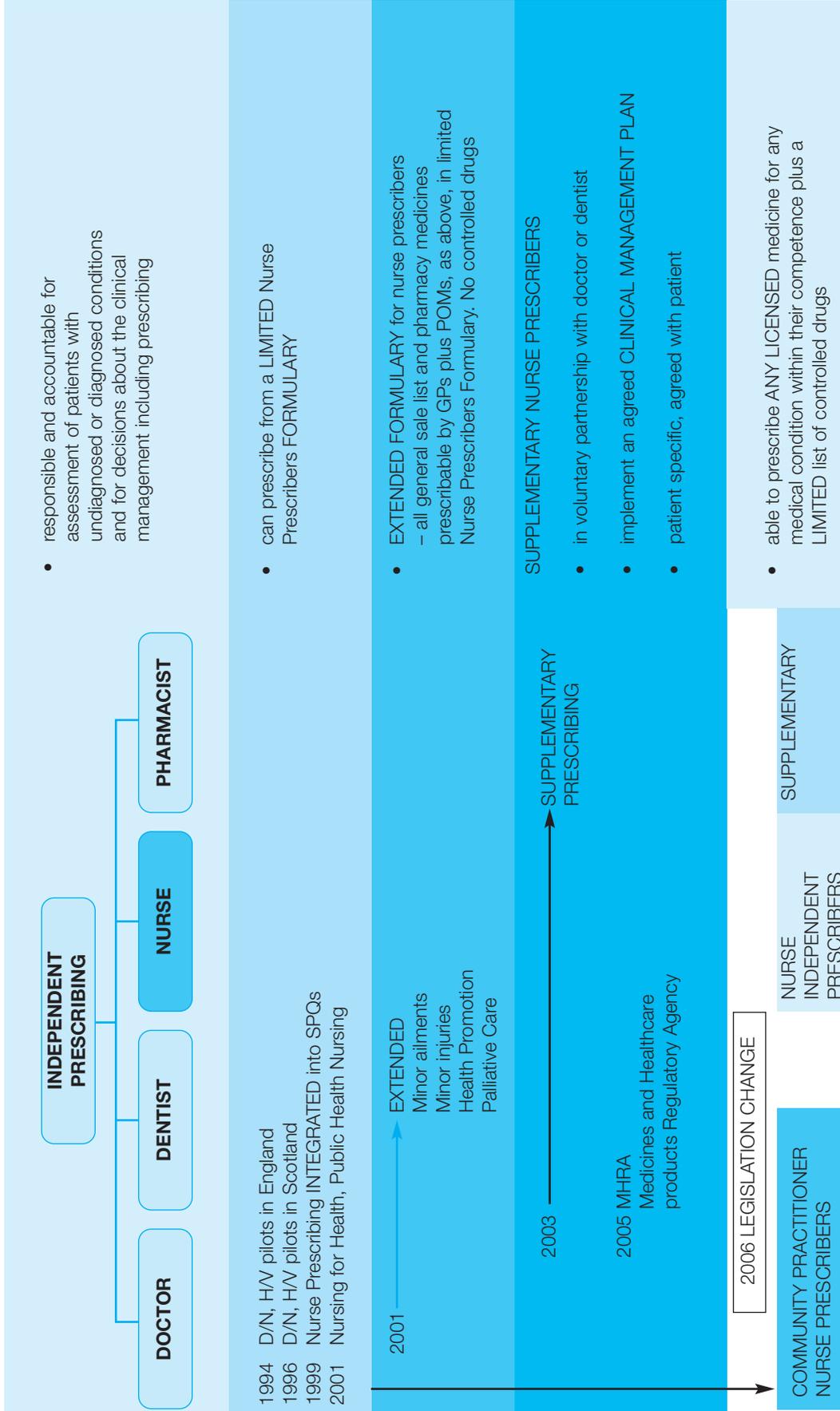
An examination to focus on outcomes which contribute to clinical competence. The student's practice is assessed as a live consultation and competency to consult, assess, diagnose and provide rationalisation for prescribing decision is assessed.

Yellow Card Scheme:

If a patient/client experiences an adverse drug reaction to a medication, the nurse should record this in the patient/client's notes, notify the prescriber (if they did not prescribe the drug) and notify via the Yellow Card Scheme immediately. Yellow cards are found in the back of the British National Formulary and online on: www.yellowcard.gov.uk. For further information read the BNF or access the MHRA website: www.mhra.gov.uk

APPENDIX 14

HISTORY OF NURSE PRESCRIBING





SCOTTISH EXECUTIVE

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