Department of
Health, Social Services
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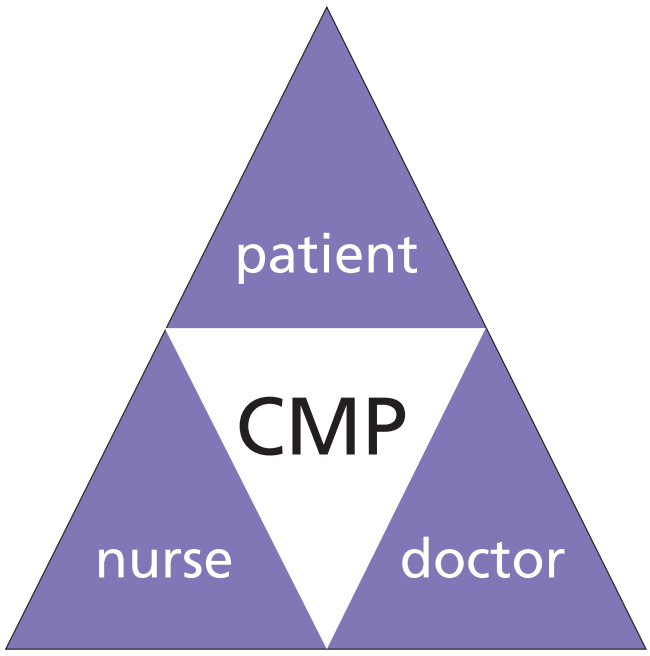
Best Practice Guidance for Supplementary Prescribing by Nurses Within the HPSS in Northern Ireland



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EHSSB

PROMOTING HEALTH SECURING CARE Northern Health and Social Services Board

Southern Health & Social Services Board

WESTERN HEALTH AND SOCIAL SERVICES BOARD

Contents

Foreword

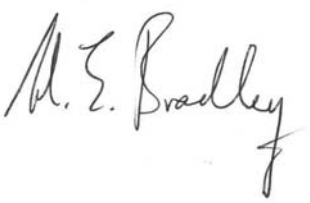
One of the primary aims of the modernisation agenda of the HPSS is to ensure it's capacity to deliver accessible and quality care to patients.

The extension of nurse[1] prescribing is one route to modernising the HPSS through developing and enhancing the role of health care professionals and increasing patients' access to medicines. The extension of prescribing is intended to provide patients with quicker and more efficient and increased access to medicines and to make the best use of nursing skills whilst ensuring patient's safety is paramount. Nurses have been undertaking training since 2002 to prescribe medicines independently from the Nurse Prescribers Extended Formulary (NPEF) and also on a supplementary basis using Clinical Management Plans.

This guidance aims to provide clear information on the practical implementation of supplementary prescribing and builds upon the information contained within the Supplementary Prescribing by Nurses and Pharmacists in Northern Ireland: A Guide for Implementation which was published in 2004.

I am confident that this guidance will further enhance the quality of care that patients receive and ensure that nurses continue to play an integral part in the development of quality patient centred care.

I wish to thank all those who contributed to the development of this guidance with special thanks to the Nurse Prescribing Advisers at the four Health and Social Services Boards, for their advice and support in the preparation of this document.



Martin Bradley
Chief Nursing Officer

1 When the term nurse is used, it refers to Registered Nurse, Midwife and Specialist Community Public Health Nurse

A Definition of Supplementary Prescribing

Supplementary prescribing is "a voluntary prescribing partnership between an independent prescriber and a supplementary prescriber to implement an agreed patient-specific clinical management plan (CMP) with the patient's agreement".[2]

Supplementary prescribing may only take place after:

- a specified point in the individual patient episode
- assessment and diagnosis by an independent prescriber
- the development of a written CMP between the independent and supplementary prescriber

Legal Basis of Supplementary Prescribing

The Medicines Act 1968 as amended by Section 63 of the Health and Social Care Act 2001 extended the prescribing responsibilities of doctors and dentists to include other health professions. The legislation has enabed the introduction of new types of prescribers, including the concept of supplementary prescribing, under certain conditions set out in the Prescription Only Medicines (Human Use) Order 1997, as amended by the Prescription Only Medicines Order 2003.

Article 63 of the HPSS (NI) Order 1972 imposes a duty on Boards to arrange for the provision of drugs, medicines and appliances ordered by medical and dental practitioners. This was amended to include; a prescribed description of registered Nurse, Midwife and Health Visitor by Article 3 of the Pharmaceutical Services (NI) Order 1992, and a pharmacist by the Article 47 of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003.

2 DHSSPS (2004) Supplementary Prescribing by Nurses and Pharmacists within the HPSS in Northern Ireland

Changes to the existing regulations under the HPSS Order 1972 in relation to pharmaceutical services, general medical services and charges for drugs and applicances, arising out of the designation of a new (supplementary) category of prescriber (both pharmacists and nurses) have now been implemented.

The Health and Personal Social Services (Primary Medical Services) (Miscellaneous Amendments) Regulations (Northern Ireland) 2005 Reg 3 (5) removes the restrictions preventing supplementary prescribers from prescribing controlled drugs or unlicensed medicines.

Aims of Supplementary Prescribing

Supplementary prescribing is intended to provide patients with quicker and more efficient access to medicines, and to make the best use of the skills of registered nurses. Over time, supplementary prescribing is also likely to reduce doctors' workload, freeing up their time to concentrate on patients with more complicated conditions and more complex treatments.

Supplementary Prescribing in Practice

Once the CMP has been agreed, supplementary prescribers can prescribe in:

SECONDARY CARE

- at ward level using the patient's prescription form (Kardex)
- within A&E department using the hospital prescription form ("flimsy")
- on prescription forms that are dispensed by the hospital pharmacy for either inpatients or outpatients

PRIMARY CARE

- using a HS21(N) prescription form
- using a paper or electronic patient specific treatment card

There are many occasions when supplementary prescribing is not appropriate. This may be indicated by the:

- complexity of the patient's condition
- complexity of the patient's current medication regime
- number of professional carers involved
- role and/or location of the supplementary prescriber

Many professionals currently recommend treatments to be prescribed by doctors. When a supplementary prescriber makes a recommendation, a CMP should be in place to support the recommendation made. However, as a letter of recommendation is not a legal prescription, the signature of the supplementary prescriber only is required.

The independent prescriber must use their discretion in accepting the recommendation made since the independent prescriber is accountable at all times for their prescriptions. Supplementary prescribers should never prescribe following a recommendation from another professional other than the independent prescriber(s) named on the CMP.

Prescribing Partnerships

In some cases it may be more practical for the supplementary prescriber to work with a team of independent prescribers. It is essential to develop good communication pathways to ensure quality prescribing. The team of independent prescribers may include:

- the Consultant, Registrar and/or Senior House Officer (SHO) who are familiar with the patient and have responsibility for reviewing the patient on an ongoing basis
- General Practitioners (GPs) who are familiar with the patient and have responsibility for reviewing the patient on an ongoing basis

Within shared care arrangements (where the patient is jointly managed between primary and secondary care) it is the responsibility of the GP to take the lead for supplementary prescribing.

The Independent Prescriber (IP)

Within the context of supplementary prescribing, the independent prescriber must be a doctor or a dentist. The independent prescriber is responsible for the assessment of patients with undiagnosed conditions and for decisions about the clinical management required, including prescribing.

The independent prescriber:

- WITHIN SECONDARY CARE
  should be at SHO level or higher, who is familiar with the patient and has responsibility for reviewing the patient on an ongoing basis

- WITHIN PRIMARY CARE
  should be a GP who is familiar with the patient and has responsibility for reviewing the patient on an ongoing basis

Responsibilities of the Independent Prescriber

The independent prescriber will be the clinician responsible for the individual at the time of the initial assessment or at the time supplementary prescribing is to begin.

Responsibilities of the Independent Prescriber include;

- determining which patients may benefit from supplementary prescribing and the medicines that may be prescribed by the supplementary prescriber under the CMP

- carrying out the clinical assessment of the patient and making the diagnosis

- reaching an agreement with the supplementary prescriber about the limits of their responsibility for prescribing and review. The independent prescriber will clearly need to take account of the experience and areas of expertise of the supplementary prescriber, as well as the professional relationship between the independent and supplementary prescriber(s), when coming to this decision

- setting appropriate review dates to assess the patient's progress
- carrying out a review of the patient's progress at appropriate intervals depending on the nature and stability of the patient's condition
- providing advice and support to the supplementary prescriber when required
- appropriate sharing of the common patient record with the supplementary prescriber
- reporting adverse incidents within local risk management or clinical governance schemes

The Supplementary Prescriber (SP)

A supplementary prescriber must be a first level Registered Nurse, Midwife or Health Visitor held on the Nursing and Midwifery Council (NMC) professional register, with an annotation signifying that the nurse has successfully completed an approved programme of preparation for supplementary prescribing. Consent of the appropriate employer should be gained prior to the commencement of supplementary prescribing. In addition, the nurse prescriber's details must be entered onto the appropriate Trust / Board register prior to commencement of prescribing.

More than one supplementary prescriber can be named on the CMP i.e. a Supplementary Prescribing Team. Teams of supplementary prescribers may include nurse prescribers and prescribers from other professional groups. It is essential to develop good communication pathways to ensure quality prescribing.

Responsibilities of the Supplementary Prescriber

The supplementary prescriber is responsible for the continuing care of patients who have been clinically assessed by an independent prescriber. Responsibilities include:

- contributing to the development of the CMP
- monitoring and assessing the patient's progress as appropriate to the patient's condition and the medicines prescribed
- altering the medicines prescribed (adding, deleting or adjusting the dosage) within the limits set out in the CMP
- recording the prescribing in the common patient record as soon as possible, after the intervention. (It is good practice that this time period should be as short as possible and agreed locally)
- reporting adverse incidents within local risk management frameworks or clinical governance schemes
- working at all times within clinical competence and the Professional Code of Conduct
- consulting the independent prescriber when necessary
- accepting professional accountability and clinical responsibility for prescribing practice
- engaging in Continuous Professional Development
- setting appropriate review dates to assess the patient's progress

The Clinical Management Plan (CMP)

A CMP is a plan of care that relates to a named patient and the specific condition(s) to be managed by the supplementary prescriber, with the patient's agreement. The independent prescriber is responsible for the diagnosis and setting the parameters of the CMP, although they need not personally draw it up. While either the independent or supplementary prescriber may draft the CMP (paper or electronic), both of them must formally agree to it in writing before supplementary prescribing can begin.

There is no requirement for items that can be prescribed independently to be included in the CMP, but these may be included as part of the overall treatment plan for the patient. The CMP remains in place for an agreed period of time, which is usually no longer than 12 months.

Review of the CMP

The independent and supplementary prescribers must maintain communication throughout the duration of the CMP. They should jointly carry out formal clinical reviews at predetermined periods both within the lifespan of the CMP and at its culmination. The final review may be undertaken jointly by both prescribers reviewing the patient together. Where this is not possible, the independent prescriber should review the patient, and subsequently discuss future management of the patient's condition(s) with the supplementary prescriber. Prescribing by the supplementary prescriber should not continue after the date of the review, as the CMP is no longer valid unless the next phase of the CMP has been agreed.

The CMP may continue after 12 months if:

- the formal review has been completed
- the patient's condition remains stable and deterioration of the condition is not expected
- current medications on the CMP are appropriate
- both prescribers record their agreement
- the patient is in agreement

If changes to the original / current CMP are required, then a new CMP should be drawn up, which documents the agreed changes.

Conditions that may be treated within the CMP

There are no legal restrictions as to the clinical conditions that may be dealt with by a supplementary prescriber. It is suggested that supplementary prescribing is most appropriate within the areas of chronic disease or enduring health needs, but is not limited to these e.g acute episodes occurring within chronic conditions may be included in the arrangements, provided they are detailed in the CMP.

Items that may be prescribed within the remit of the CMP

The CMP may include all prescribable General Sale List (GSL), Pharmacy (P) or Prescription Only Medicines (POM).

Key Recommendations

- A supplementary prescriber should not agree to prescribe any medicine outside his / her area of competence.
- Within the CMP, medicines may be described by their therapeutic class or named as specific products, and reference made to the relevant section in the BNF if appropriate. Some therapeutic classes of drugs (e.g. analgesics) would be considered too extensive to be meaningful and it would be more useful to include a more specific therapeutic group (e.g. non-opioid analgesic) or state the specific drug(s).
- The supplementary prescriber has discretion in the choice of dosage, frequency and formulation within the range specified in the CMP.
- The CMP should make reference to recognised evidence based guidance (local or national, e.g. NICE, PRODIGY, CREST). Any guidelines referred to should be readily accessible to both prescribers when managing the patient's care.
- CMPs should reflect local formulary recommendations.
- Prescriptions should be written generically (except where this is not appropriate e.g. modified release preparations, anticonvulsant medications, combination products).

Prescribing of Controlled Drugs

Controlled drugs can be prescribed on a supplementary basis. Prescribers should follow the guidance on the prescribing of controlled drugs as stated in the British National Formulary (BNF).

Prescribing of Specialist Medicines

Specialist medicines are defined as medicines, which have significant pharmacological complexity and / or rarity of use to make the prescribing of these medicines relatively uncommon. Patients taking specialist medicines may have complex monitoring requirements and specialist knowledge is required for the appropriate interpretation of results.

Specialist medicines may be incorporated into the CMP, however, before undertaking a supplementary prescribing arrangement involving specialist medicines:

- the independent prescriber must have assured him / herself that the supplementary prescriber has the level of knowledge to take part in such an arrangement
- the independent prescriber must have agreed with the supplementary prescriber the specific monitoring requirements to support the safe and efficacious use of these drugs
- the supplementary prescriber must be working in their area of competence and should incorporate the shared care guidance issued by the Regional Group on Prescribing of Specialist Medicines, as appropriate.

Consent

The principle underlying the concept of supplementary prescribing (i.e. a prescribing partnership) must be explained in advance to the patient / carer by the independent or supplementary prescriber and their agreement should be obtained prior to entering into a supplementary prescribing agreement. The patient's agreement (verbal or written) should be recorded in the CMP. Without such agreement supplementary prescribing cannot proceed.

Legal Issues

Legally a CMP represents a formal agreement between the independent and supplementary prescriber. Although there is no legal requirement for the CMP to be signed, the Nursing and Midwifery Council (NMC) advises that the formal agreement needs to be demonstrable. Therefore the CMP should be signed by the independent prescriber and the supplementary prescriber prior to the commencement of supplementary prescribing. Agreement could take the form of:

- signatures of the independent and supplementary prescribers on the paper copy
- signatures of the independent and supplementary prescribers electronically (providing an audit trail exists)
- written agreement from the independent prescriber if the CMP has been written by the supplementary prescriber (e.g. memo or email)
- written agreement from the supplementary prescriber if the CMP has been written by the independent prescriber (e.g. memo or email)

Supplementary nurse prescribers are professionally accountable to the NMC and must act in accordance with the Code of Professional Conduct. Supplementary prescribers should discuss professional indemnity insurance with their professional organisation or trade union.

Job descriptions should also reflect that nurse prescribing is encompassed within the role.

Changes to the Independent Prescriber(s)

The independent prescriber should be the clinician responsible for the individual's care at the time that supplementary prescribing commences. If this responsibility moves from one independent prescriber to another, the supplementary prescriber may not continue to prescribe, unless he / she negotiates a new agreement to enter into a prescribing partnership with the new independent prescriber. A new CMP should be drawn up and the agreement of the independent prescriber, supplementary prescriber and patient must be recorded.

Essential details which must be included on the CMP are:

- the name of the patient
- the illness or conditions which may be treated by the supplementary prescriber
- reference to evidence based guidance (local or national e.g. NICE, PRODIGY, CREST)
- reference to the medicines (by individual medicine or therapeutic class of medicines) that may be prescribed by the supplementary prescriber for the named patient
- the circumstances within which the supplementary prescriber can vary the dosage, frequency and formulation of the specified medicines
- the circumstances in which the supplementary prescriber should refer back to the independent prescriber
- known allergies and adverse drug reactions
- relevant arrangements for the notification of any adverse reactions
- the date on which the supplementary prescribing arrangements commence and the dates by which the arrangements should be reviewed (ongoing and final reviews)
- a record that the independent prescriber, supplementary prescriber and patient have agreed to the details within the CMP

Use of CMP templates

Protocol templates may only be used as a reference in the development of the CMP and supplementary prescribers must remember that the key characteristic of the CMP is that it is **patient specific.**

Record of the CMP

The CMP should form part of the common patient record. For example, the CMP should be kept with the medicines Kardex or in the patient's record in the acute care setting and in the patient's record (electronic or paper) within a GP practice. Where patients are being managed by both primary and secondary care, the CMP should be retained in the hospital medical records **and** a copy should also be sent to the GP.

Evaluation, Audit and Clinical Governance of Supplementary Prescribing

The supplementary prescriber, together with their employer, must put in place specific actions to regularly evaluate the effectiveness, appropriateness, safety and acceptability of their prescribing.

For example,
Liaison with the pharmacy department and or audit department in the acute sector to:

- carry out retrospective prescribing audits
- review of case notes
- reflect on significant prescribing events
- patient surveys

Within primary care:

- regular review of prescribing data using Northern Ireland Nurse Analysis (NINA) reports
- audit of practice data
- reflect on significant prescribing events
- patient surveys

Record Keeping

Best practice recommends that:

- arrangements for sharing patients' records should be established when the supplementary prescribing partnership is set up
- details of both the consultation and the prescription should be recorded on the shared record
- the prescription details should also be entered into the nursing patient record (if a separate nursing record exists)
- prescription details should be recorded as soon as possible and agreed locally
- the record of the prescription must be appropriately documented:

  IN SECONDARY CARE

  as an annotation of the supplementary prescriber in the paper records (patient's notes and Kordex).

  IN PRIMARY CARE

  as an annotation of the supplementary prescriber in the patient's record (written or electronic). If recorded electronically the appropriate Read Code (e.g. 8B2E.00 prescription by nurse) should be used.

Record of the Prescription Details

As the prescriber is ultimately responsible for the recording of the prescription, the prescriber should enter the prescription details themselves into the prescribing section of the patient's record. Where this is not immediately possible a carbon copy of the nurse prescription may be used. One copy will be for the patient's GP. The supplementary prescriber must make local arrangements with the independent prescriber as to how prescription details will be transferred from the carbon copy to the prescribing section of the patient's record. The second copy should be retained within the nursing record if appropriate.

Where a supplementary prescriber does not have direct access to the common patient record the following alternatives may be agreed:

- email the designated recipient at the GP practice with the patient's prescription details, who will then record as detailed above.
- telephone the practice to inform them that a fax detailing the patient's prescription is to follow. The designated recipient at the GP practice would then confirm receipt of the fax and record as described above.
- in exceptional circumstances only, send prescription details to the designated recipient, via the postal recorded delivery service.

It is not appropriate to telephone prescription details under any circumstances. This system increases the risk of error and does not establish an audit trail.

Scenarios

These scenarios have been developed to give a brief overview as to how supplementary prescribing can be utilised in practice.

SCENARIO 1: Primary Care

Situation

A Nurse Practitioner with Extended Independent and Supplementary Prescribing qualification, works in a paper-lite (i.e. most records are computerised) GP surgery. She uses her supplementary prescribing qualification in the ongoing treatment of patients attending the asthma clinic.

Issues

- Demonstration of agreement to the use of a Clinical Management Plan (CMP)
- Use of protocol template CMPs
- Recording of prescriptions issued to patient

In-Practice

1. To enable the supplementary prescribing arrangement to occur, the Independent Prescriber (i.e. the GP) must diagnose the patient's condition. The GP then refers the patient to the nurse prescriber for ongoing care.
2. The CMP may be developed by the GP, the nurse or by both of them, but agreement to the use of CMP must be demonstrated by both. Agreement by the patient should also be documented before the nurse may legally prescribe for a patient.
3. If the nurse develops the CMP she could email a copy to the GP asking for an email in response indicating his agreement (and vice-versa if developed by the GP).
4. It is not necessary to print a copy of the CMP for all individuals to sign, since all of the patient's records are in electronic format. However, emails demonstrating agreement to the use of the CMP must be retained in the pre-determined section of the patient record, for the purposes of an audit trail.
5. An alternative would be to print the CMP and obtain signatures of the Independent and Supplementary prescribers. This can then be scanned onto the patient's record.
6. A template CMP may be used to aid development of the CMP for an individual patient, ensuring that it is specific to the needs of the individual patient.
7. Currently the computer software packages used by the GP surgeries do not enable a nurse prescriber to print a prescription, therefore the nurse electronically records the details of any prescription written as soon as possible after it has been generated, using Read Code (8B2E.00 prescription by nurse).

SCENARIO 2A: Secondary Care

Situation

The supplementary prescriber (Nurse Specialist) is based at one hospital within the Trust and the independent prescriber (Consultant) is based at another site. After seeing the hospital in-patient, the Consultant makes a diagnosis and then refers the patient to the Nurse Specialist for ongoing care.

Issues

- The Consultant and the Nurse Specialist are unable to have face-to face consultations regarding the patient's condition.

In-Practice

1. The Consultant diagnoses the patient's condition and draws up and signs a written patient specific clinical management plan (CMP).
2. The patient is then referred to the Nurse Specialist for ongoing care. The CMP and the letter of referral are sent internally by the Consultant to the Nurse Specialist.
3. The Nurse Specialist assesses the patient's suitability for management of their condition under the parameters of the proposed CMP. If the nurse agrees to enter into a supplementary prescribing arrangement for this patient the CMP should be signed and retained in the patients notes. (If changes are required to the CMP it should be sent back to the IP for formal agreement).
4. The patient's agreement to the proposed supplementary prescribing arrangement is recorded and the Nurse Specialist will sign the CMP.
5. At this point, the Nurse Specialist can legally prescribe for this patient on the hospital Kardex. The prescribing is recorded in the nursing records and annotated as that of a supplementary prescriber.
6. The patient specific CMP is then stored with the medicine Kardex (unless Trust policy states otherwise).
7. Medicines are administered in accordance with the details on the medicine Kardex.
8. Following discharge the CMP is retained in the patient's record.

SCENARIO 2B: Out-patient Follow-up Post Discharge

The same patient is discharged from hospital and requires ongoing care for the condition specified in the CMP. The patient is reviewed by the Nurse Specialist in the out-patient department.

Issues

- The Nurse Specialist writes a 'letter of recommendation' for medications to be prescribed by the GP.

In-Practice

1. For information purposes and continuity of care the Nurse Specialist will send the GP a copy of the CMP with the letter of recommendation.

2. The GP is now the independent prescriber and has responsibility for prescribing for the patient in primary care.

3. The GP may want to utilize the contents of the inpatient CMP as a guide for ongoing care. A new CMP could be drawn up between the GP and Practice Nurse (who is an extended independent and supplementary nurse prescriber) if all parties are in agreement for a supplementary prescribing arrangement.

SCENARIO 3: Patient Jointly Managed by Primary and Secondary Care

Situation

A Diabetes Nurse Specialist (DNS) is employed by a Community Trust. The DNS receives referrals from primary and secondary care following the diagnosis of diabetes by the Diabetes Consultant. The DNS reviews her patients in both domiciliary settings and outpatient settings. To enable the DNS to prescribe as a supplementary prescriber from a CMP, protocol templates have been drawn up and agreed with the Diabetes Consultant. In this case the patient's diabetes is stable at the 12 month review and the independent (GP) and supplementary prescriber agree to continue with the current CMP.

Issues

- working under shared care arrangements between primary and secondary care
- DNS does not have direct access to either primary or secondary care patient records
- recording of prescriptions issued to patient is difficult
- DNS does not have email access.

In-Practice

1. The Diabetes Consultant makes the diagnoses of diabetes and then refers the patient to the DNS for on-going care.
2. The DNS assesses the patient's suitability for management of their diabetes under the parameters of the CMP protocol template.
3. The DNS individualises the CMP for this patient and obtains their agreement to the proposed CMP.
4. The DNS phones the GP and alerts him to an incoming fax (if in accordance with Trust policy) which details the patient specific CMP. A member of the practice staff scans the faxed copy of the CMP onto the patient's electronic records.

5. As agreement to the use of CMP by the independent prescriber must be demonstrated the nurse receives a fax in response indicating the agreement of the GP. The fax is retained in the DNS patient's record, for the purposes of an audit trail.

6. At this point the DNS may legally prescribe for this patient using a nurse prescription form HS21N.

7. To record prescriptions generated for this patient, the DNS uses the carbonised prescription copy pad and enters one copy into her own records immediately. The DNS then phones the surgery to inform them of an incoming fax, and then faxes the remaining duplicate copy to the GP surgery at the end of her clinic.

8. The details of the prescription are transcribed by the practice staff and added onto the prescribing section in the patient's electronic record.

Annex 1

CMP Template 1 (Blank)
(for teams who have full co-terminus access to patient records)

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

Agreed by Independent Prescriber(s)	**Date**	**Agreed by Supplementary Prescriber(s)**	**Date**	**Date agreed with patient/carer**

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

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

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