Enhancing Primary and Community Care

Non-Medical Prescribing

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1 Introduction

The non-medical prescribing working group has focused on the promotion of non-medical prescribing to enable care to be delivered differently in community and primary care settings through improved use of skill mix in pathways of care. The current progress has been reviewed to identify the opportunities and barriers to future development, which if addressed, would enable the HPSS to maximise the benefits to patient care from non-medical prescribing thereby reducing reliance on hospital, outpatient and A&E services.

The benefits of non-medical prescribing in addition to traditional medical prescribing are described as;

- Improved access for patients to medicines in a variety of settings, hospital, primary and community care
- Appropriate use of professional knowledge and skills
- Ability for professionals to complete episodes of care without involving another professional for purposes of prescribing
- Freeing up doctor time for more appropriate tasks e.g. allowing them to focus on more complex cases
- Improved teamwork in multidisciplinary teams
- Clinical governance and appropriate accountability

2 Current Position

2.1 General – UK wide

There are currently three types of non-medical prescribing:

- The Nurse Prescribers' Extended Formulary gives those trained as independent prescribers access to 240 prescription-only medicines, including some controlled drugs, to treat around 110 medical conditions. Currently over 6,100 nurses are qualified as extended formulary nurse prescribers.

- Nurse Prescribers' Formulary for District Nurses/Health Visitors (Community Practitioners). Over 29,000 district nurses and health visitors are able to prescribe from a more limited formulary comprising a limited range of medicines, dressings and appliances suitable for use in community settings.
- Supplementary prescribing enables qualified nurses and pharmacists to prescribe any medicine (including controlled drugs), within the framework of a patient- specific clinical management plan, agreed with a doctor. Over 5,700 nurses and 450 pharmacists in England are presently qualified to do this.

Since April 2005 physiotherapists, chiropodists/podiatrists and radiographers, have also been able to qualify as supplementary prescribers. Changes to regulations to enable optometrists to train and register as supplementary prescribers came into force in July 2005.

Health Secretary Patricia Hewitt recently announced that from Spring 2006, qualified Extended Formulary nurse prescribers and pharmacist independent prescribers will be able to prescribe any licensed medicine for any medical condition – with the exception of controlled drugs. Changes to medicines and NHS regulations are planned by April/May 2006

2.2 Progress in Northern Ireland

In Northern Ireland, the following groups can act as supplementary prescribers subject to the appropriate training:

- Registered nurses
- Midwives
- Pharmacists
- Chiropodists
- Podiatrists
- Physiotherapists
- Diagnostic / therapeutic radiographers
- Extended Formulary Nurse Prescribers
- Registered Optometrists

Nurses can also be trained as independent prescribers to prescribe from the extended formulary.

- In Northern Ireland nurses are trained as both Extended Independent and Supplementary prescribers. Currently over 170 nurses are qualified as extended independent and supplementary nurse prescribers and a further 70 are in training in the current academic year.
- Over 1060 district nurses and health visitors are able to prescribe from a more limited formulary comprising a limited range of medicines, dressings and appliances suitable for use in community settings.

- Pharmacists may be trained as supplementary prescribers to prescribe any medicine (including controlled drugs), within the framework of a patient- specific clinical management plan, agreed with a doctor. Currently, 53 pharmacists have completed their supplementary prescribing training (12 primary care pharmacists and 41 secondary care pharmacists). The current course, which is due to finish in January 2006, has 11 pharmacists, 8 from primary care and 3 from secondary care.

- The recent announcement by Patricia Hewitt that qualified Extended Formulary nurse prescribers and pharmacist independent prescribers will be able to prescribe any licensed medicine for any medical condition – with the exception of controlled drugs - will also apply in Northern Ireland following the necessary changes to legislation. This announcement has been welcomed and is expected to address concerns that the Nurse Prescribers' Extended Formulary was too complex and that supplementary prescribing could not be used in all settings where patients would benefit, such as emergency care, as the clinical management plan must be prepared in advance. Introduction of independent prescribing by pharmacists is intended to benefit patients by providing greater access to pharmacists' knowledge and expertise, as well as a faster and more accessible service.

- The timetable for the introduction of the necessary legislation for enabling qualified Extended Formulary nurse prescribers and pharmacist independent prescribers to be able to prescribe any licensed medicine for any medical condition – with the exception of controlled drugs - in Northern Ireland has not yet been defined.

2.2.1 Nurse Prescribing

In Northern Ireland, nurses are actively prescribing as independent and supplementary prescribers in primary care, community and acute settings;

For example

- Palliative care
- Chronic disease management
- Emergency nurse practitioners in A&E
- Non-registered patients e.g homeless
- Specialist nursing clinics e.g Colorectal nurse in Foyle, Leg ulcer clinics

The development of first contact care roles will also provide opportunities for nurses and allied health professionals to prescribe.

Current prescribing data in primary care shows that 62% of nurses who are trained to prescribe are actually prescribing. From April to October 2005, 36,358 prescription items were prescribed by nurse prescribers. This represents a 14% increase from the previous year. However, there are significant numbers of nurses who have prescribed less than 5 items.

The restricted formulary available to independent nurse prescribers has limited the ability of some nurses to prescribe within their clinical areas. The proposed extension to include all drugs in the BNF except controlled drugs will provide greater scope for prescribing in enhanced roles in;

- Chronic disease management
- medicines management / medication review
- emergency/urgent care/unscheduled care
- mental health
- specialist areas
- non-registered patients e.g homeless
- palliative care

Practitioners already involved in multidisciplinary teams delivering services in these areas will be able to prescribe within their own level of competence to complete episodes of care and improve patient access to appropriate medicines. The new legislation will

also support new service developments in these and other areas of patient care through enabling new ways of working.

It is now possible for any nurse to prescribe from the Community formulary, a role previous restricted to District Nurses and Health Visitors, however, the only programme available to prepare nurses for this role is known as Mode 2 prescribing which forms an integrated part of community specialists programmes. This is unlikely to have a big impact on the numbers of nurses qualified to prescribe.

2.2.2 Pharmacist Prescribing

Across the trusts in Northern Ireland, pharmacist supplementary prescribers have successfully developed their role and are prescribing in renal, anticoagulant and rheumatology services. Others are developing their prescribing role in services such as cancer, palliative care, total parenteral nutrition, paediatrics and respiratory medicine.

A number of primary care pharmacists are currently in the process of applying to their respective HSSB to obtain funding for providing a pilot supplementary prescribing service to their patients. It is anticipated that these pharmacists will either work from their community pharmacy, or from a GP surgery. Their projects are focusing on the following clinical areas; Hypertension, Dermatology, Asthma, Benzodiazepine withdrawal clinics.

3 Outcome measures

The following outcome measures may be useful in monitoring the uptake of non-medical prescribing both in terms of numbers and range of services in which non-medical prescribing is being incorporated into pathways of care.

- Number of non-medical prescribers trained and number within each type of non-medical prescriber trained (e.g. nurse, pharmacists, AHP)
- Percentage of those trained that are actively prescribing (NB this data may only be available for primary care)
- Prescription volume data (only primary care)
  - Numbers of items prescribed – total and by prescriber type

  - Number of items by each therapeutic area/speciality
- Uptake of non-medical prescribing in different care setting/services/specialities
  - volume of items prescribed
  - number of prescribers
- Qualitative data
  - satisfaction surveys – patients, carers, colleagues
- Time from qualification to active prescribing as a measure of improved processes and more appropriate choice of individuals to be trained.

Baseline information is not currently available for all these measures. In Primary Care, the data will be readily available through the database at CSA, however, it is not currently analysed to produce the information necessary information to enable monitoring of the above outcome measures. This information is not routinely collected in secondary care and is therefore not currently available.

4 Evidence

Nurse prescribing has been implemented in the HPSS in Northern Ireland and the rest of the UK since 1999. Extended formulary independent nurse prescribing was introduced in early 2002. A national evaluation of the development of extended formulary independent nurse prescribing was commissioned by the Department of Health to inform future policy, education and practice[1]. The findings of the research indicated that nurses are prescribing frequently and clinically appropriately in a range of practice settings and that the expansion of independent nurse prescribing is largely viewed as successful on a range of policy and practice dimensions. Patients were generally positive about their experience of nurse prescribing and considered ease of access to obtain their medicine from a nurse rather than a doctor to be a major advantage. Doctors were positive about the development of nurses within their teams, although were not able to unequivocally conclude that it had reduced their workload.

Local research into health visitor attitudes to prescribing within Northern Ireland found that while health visitors felt that nurse prescribing provided patients with convenient prompt access to

care, many health visitors were still not prescribing for a variety of reasons[2].

In her research in Northern Ireland, Loretta Gribben found that more than half of the nurses involved in the survey had the clinical opportunity to use their independent and supplementary prescribing powers, however only 22.7% were currently prescribing from the extended formulary and more than half were not prescribing[3]. A variety of reasons for non-prescribing were given including; "unavailability of prescription pads", "awaiting prescribing code", "impracticalities due to trust-wide remit" and "not working in an area of practice that lends itself to extended independent or supplementary nurse prescribing". Recently qualified nurse prescribers have also reported that there are many short and long term problems that need to be resolved before it can be successfully embedded in practice and may depend on organisational support and robust CPD. [Bradley et al][4]. A review of the use and effectiveness of independent nurse prescribing by two practice nurses in Sussex found that extended nurse prescribing was useful and effective within its limitations. [Kimmer & Christian][5].

Examples of the development of non-medical prescribing in specific clinical settings have been reported;

- Supplementary prescribing by nurses in out-patient renal services – patients seen in pre-dialysis clinic, patients receiving haemodialysis, peritoneal dialysis, day care procedures and transplantation. The use of supplementary prescribing within clinical management plans is reported to have empowered those best placed to make decisions on the care and treatment of their patients.[6]
- Role re-design of diabetic specialist nursing in Peterborough including the use of nurse prescribing is currently being evaluated by University of Reading.[7]

There are some local examples of how non-medical prescribing is developing in Northern Ireland as outlined in the following case studies;

- **Improved access for patients to medicines in a variety of settings, hospital, primary and community care**

A Cardiac Research Nurse in Altnaglevin Hospital has been using supplementary prescribing to prescribe for 55 patients involved in Cardiology Clinical Trials. She prescribes the clinical trial drugs under an agreed clinical management plan. There has been a positive reaction from both the patients and the Consultants involved in nurse supplementary prescribing.

A nurse led walk-in health clinic has been developed within the Glenfield Estate in Carrickfergus, which has been designated as a disadvantaged area. The project targets the needs of this marginalised community, providing first contact care and a flexible service. The Nurse Practitioners have adopted new professional roles and are offering care in a non-traditional health care setting. The expansion of professional boundaries, developing the role of the Nurse Practitioner, has included Extended Independent and Supplementary Nurse Prescribing. This has improved patient accessibility to prescribed medication, increased local support to general practices by reducing pressure on local treatment rooms and has improved the health and well-being of the target population. This project is being evaluated as part of the overall redesign of community nursing.

The single Homeless Health Care is a nurse led initiative, operational amongst an identified group of single homeless people in North and West Belfast. The Health Care Co-ordinator, is a qualified nurse practitioner who has completed the Independent and Supplementary prescribing course allowing timely access to treatment and medication for those whose condition would otherwise reach crisis point or lead to more chronic stage. The adverse effects of homelessness and health are well documented – this is true for a wide range of health issues: diet and malnutrition, substance misuse, mental illness, sexual health problems, infectious diseases and problems related to living conditions (respiratory, hypothermia, trench foot) and lifestyles (cardiovascular disease). Many of these are minor healthcare problems which if untreated become life threatening or chronic disorders that represent a potential risk to the public. It has been our experience that homeless people expend tremendous energy on survival strategies such as food, warmth, shelter and a place to rest and only then do they consider their health. Independent prescribing has made a real change to those homeless who do not have GP registration such as street sleepers and the increasing immigrant homeless population many of whom will not access formalised health care. This year independent prescribing allowed some two hundred flu vaccines to be administered to this vulnerable population.

Independent Prescribing for those working in prostitution has been especially useful for condition such as Urinary Tract Infections, Sexually Transmitted Infections, mouth ulcers and contraceptives.

Timely treatment for this client group not only improves their health but has a public health benefit

- **Appropriate use of professional knowledge and skills**

A stoma care service is currently available in Foyle Health and Social Services Trust for patients with existing stomas, a fistula, and awaiting surgery or newly diagnosed. This service has been set up as a first point of contact and an integrated care pathway for patients with rectal bleeding across the Trust and within a variety of settings. It embraces the concepts of patient empowerment, health promotion and a holistic approach to care. The Colorectal Nurse has been using her prescribing qualification to independently prescribe stoma products to patients from up to 22 general practices. She has been assigned an individual prescribing budget of £50,000 as part of a non-medical prescribing pilot, which allows her to carry only one prescription pad. It is anticipated that this service will be extended to supplementary prescribing, in partnership with general practice and consultants to provide chronic disease management e.g. Crohn's Disease and Diverticular Disease.

A Nurse Practitioner working in Minor Ailments, which is part of Antrim A&E department, sees approximately 35-40 patients per day following triage in A&E, without the need for any medical intervention. The Nurse Practitioner's role has effectively reduced waiting times for patients presenting with a wide range of illnesses and injuries, for example soft tissue injuries, otitis media, otitis externa, conjunctivitis, corneal trauma, abrasions and insect bites. The Nurse Practitioner is able to use her extended independent nurse prescribing qualification when assessing, diagnosing, deciding on appropriate treatment, prescribing and advising. She also takes responsibility for delegating administration of prescribed medication to other nursing staff. There is reduced need for Patient Group Directives (PGD's), which are required to be updated regularly. A recent self review by the Nurse Practitioner indicated her consultations accounted for approximately 40% of all A&E attendances.

- **Ability of professionals to complete episodes of care without involving another professional for purposes of prescribing**

A Nurse Practitioner in a general practice in Strabane has been using her extended independent prescribing qualification to prescribe for patients with minor illnesses and for gynecology problems, family planning and travel health. Extended Independent Nurse Prescribing has allowed her to move towards working as an autonomous practitioner. This has been a change from the traditional role of the Nurse Practitioner, where she would have had to consult with the GP to arrange a prescription for the patient. She has concluded that this is a much more satisfactory way of working and reaction from the patients and GPs has been very positive.

A Registered Nurse Grade E working in a 21 bedded Rehabilitation and Palliative Care Unit in the Moyle Hospital is using her extended independent prescribing qualification to prescribe for Palliative Care patients (for e.g. in relation to excessive respiratory secretions, nausea and restlessness), and for patients with other medical conditions such as urinary tract infection and constipation. Long term patients are also prescribed influenza vaccination. This stand alone unit cares mainly for elderly patients who are waiting for nursing/residential home placements or to go home. Medical cover is limited to an on-call service in the evenings and at weekends, which means that the nurse can prescribe for specific conditions therefore on-call doctors do not need to be called in from home and patients receive necessary treatment when required. This is very important in Palliative Care as the patient's condition can change very quickly.

- **Freeing up doctor time for more appropriate tasks e.g. allowing them to focus on more complex cases**

An Anticoagulant Pharmacist employed at Craigavon Area Hospital has been managing anticoagulant clinics on three sites i.e. Craigavon Area Hospital (CAH), South Tyrone Hospital (STH) and Daisy Hill Hospital (DHH). She deals with all new patients, review appointments, patients who do not attend and patients who are due to stop anticoagulant treatment and gives advice to

patients who have dental appointments or surgical procedures requiring the patient to omit anticoagulant doses. Patients are referred to the anticoagulant clinics from the wards, from GP surgeries and from out-patient departments. Patients are educated about their anticoagulant treatment on their first visit and are issued with information about anticoagulant treatment and clinic routine. After their first attendance, a clinical management plan (CMP) is implemented that allows the pharmacist to recommend a warfarin dose (or an alternative anticoagulant, if specified) based on their INR result, and prescribe enoxaparin and vitamin K if required. The clinics in STH and DHH are now completely pharmacist-led and there is no requirement for a doctor to attend these clinics. The pharmacist is backed up by two other pharmacist supplementary prescribers who are all named as supplementary prescribers on the CMP, which ensure that the clinic is adequately staffed at all times. Due to the involvement of pharmacists at these clinics, doctors' time at the clinic is removed – two half-days of a SHOs time in STH and DHH – which has had an impact on the SHO rota. In CAH, the consultant is not required for the anticoagulant clinic on a regular basis, which allows her to be available on the ward or at alternative out-patient clinics.

The "Keeping in Mind" project has been developed by the Specialist Dementia Team in Armagh and Dungannon HSST. The project leader is the Specialist Dementia Nurse who has qualified as an extended independent and supplementary nurse prescriber. This project ensures that at the time of diagnosis and prescribing of dementia drugs, there is a system in place to ensure that necessary information and advice is given to the dementia sufferer and their carer. Titration, review and monitoring of medication are carried out by the Specialist Dementia Nurse through the use of supplementary prescribing. This frees up the Consultant's time to see new patients. This allows more efficient treatment of the patient and maximises the expertise of the prescribing nurse. The effectiveness measure is to see a reduction in time that new patients have to wait to see the Consultant.

- **Improved teamwork in multidisciplinary teams**

A Renal Pharmacist employed in Antrim Area Hospital is supplementary prescribing for approximately 60 haemodialysis patients. Blood tests are performed on the patients on the first

week of each month and the pharmacist will see the patient that week to adjust their EPO (NeoRecormon® and Aranesp®) and IV iron therapy (Venofer®). The pharmacist and the Consultant are extremely happy with how the supplementary prescribing arrangement is working. It has proved to be of benefit to patients, since it is provides a much more efficient service to them, in terms of changing their doses sooner (quite often the doctor may not have changed their doses to the second week in the month, at which stage Hb levels could have risen significantly). The patients have also benefited from the pharmacist having more time to explain their medication regime to them and it has greatly improved the pharmacist and patient relationship. An audit carried out in Sept 2005 showed that in the patient group looked after by the supplementary prescriber, the percentage of patients whose Hb reached target levels (as laid down by European Renal Association Best Practice Guidelines) rose from 64% at baseline, to 86%. Supplementary Prescribing has benefited the Consultant by allowing her more time to discuss other matters with patients. In outpatient setting the medical staff may review the patient less frequently, because they may only have been on short reviews, to look after their EPO treatment. The service is now well established and a Renal Nurse is currently training to become a prescriber and to work as part of this service.

5 Cost

No costs have yet been identified to address the issues raised by this paper, however the recommendations may have financial implications.

Costs for training additional prescribers will be identified through the DHSS&PS as part of the existing plans for roll-out of non-medical prescribing.

6 Impediments/constraints/Risks

The experience of roll-out of nurse prescribing since 1998 and more recently the development of supplementary prescribing for pharmacists has identified many problems, many related to historical systems and work patterns. Lessons must be learned from this experience to inform the further roll-out of independent

prescribing for nurses and pharmacists and the developments in prescribing for allied health professionals and optometrists.

The working group identified a number of barriers, challenges and constraints in the development of non-medical prescribing and these are listed in Appendix 1. Three main barriers to greater uptake of non-medical prescribing and the realisation of its full potential to deliver patient benefits were identified and are explored in more detail as follows;

6.1 Access to prescribing budgets for prescribing in community and primary care

- Currently the budget for prescribing is allocated from the Department to the Board as an Indicative Prescribing Amount and is then allocated to GP practices on a capitation basis for their practice populations. All prescribing in primary care is attributed to GP practice budgets.
- Non-medical prescribers currently have no identified prescribing budget. This means that within primary care each prescriber has a prescription pad for each GP practice for whom they prescribe. For nurse specialists working across a locality or Board area, this would mean that they each have to carry multiple prescription pads, perhaps in excess of 60 prescription pads depending on their specialist area. This introduces impracticalities such as safe-keeping of multiple pads.
- Prescribing information is currently derived from the Pharmaceutical payments system and is based on the use of a unique cypher number, which links a prescriber to a prescribing budget (currently practice based). Cypher numbers have been used for many years and in their current format are an intrinsic part of the complete prescription data collection, payment and information systems. The CSA have considered the implications of implementing the recommendations of the Shipman report and have highlighted that, eventually, changes to the CSA system will be needed in order to ensure that every prescription generated by a GP can be accurately attributed to an individual doctor. Future design of this system must take account of the financial and clinical governance requirements for all prescribers.
- Homefirst was tasked by the DHSSPS and the CSA in August 2004 to pilot the use of a single multi-cypher prescription pad across all the nurse prescribers within Homefirst. This was an

attempt, to reduce the risks presented to prescribers through using multiple prescription pads and also to increase their potential to prescribe. The pilot demonstrated that CSA systems cannot cope with processing single multi-cypher prescriptions.

The only viable solution is to create a non-medical prescribing budget which attributes costs to prescribers and the services that they deliver rather than to GP practice populations. However, although this solution will enable non medical prescribing to progress in community settings because prescribers will no longer be required to carry multiple pads, data analysis and comparison of prescribing in similar populations will be limited.

Recommendation

- A non-medical prescribing budget should be created to facilitate current nurse prescribing and future prescribing by pharmacists, allied health professionals and optometrists in primary care.

- A new system for monitoring prescribing patterns of all prescribers should be designed to take account of clinical governance requirements of all current and future prescribers.

6.2 Access to patient records and recording of the drugs prescribed in patient records

A record of prescriptions written by a non-medical prescriber must be made in a patient's medical notes within 48 hours. This presents a number of practical difficulties in situations such as;

- Services delivered at locations that are remote from GP practice and when the patients treated are from multiple practices, it is difficult for a non-medical prescriber to comply with the recording requirements in personal and information transferred by phone/fax may not be reliably recorded.
- Services delivered within a GP surgery but the clinical system does not have the software to enable non-medical prescribing and therefore computer generated prescriptions with recording in clinical notes is not feasible.
- Access for non-medical prescribers to GP clinical notes at GP practices, i.e non-medical prescribers may not be authorised to use clinical systems to add prescribed drugs to records or to view clinical records. There may also be issues related to data

protection and lack of necessary IT skills to record the drugs prescribed.

Recommendation

- Options to enable electronic transfer of information from non-medical prescribers to GP clinical records and appropriate access for non-medical prescribers to GP clinical notes needs to be explored to facilitate easier record keeping and enable non-medical prescribing to reach its full potential, particularly in locations remote from GP practices.

6.3 Competence to prescribe

Non-medical prescribers have experienced delays between completion of their prescribing qualification and starting to prescribe. These delays have resulted in loss of confidence and reluctance to prescribe. Peer support and Continuing Professional Development are essential to ensure that the resources invested in training and preparing these individuals to be prescribers is not wasted. Some of the delays are related to process and with experience, action is being taken to minimise those delays.

The other main reason for delay between qualification and prescribing is that, following qualification, non-medical prescribers are not working in roles which enable them to prescribe. This has been highlighted for pharmacist supplementary prescribing, where students wishing to train as supplementary prescribers are not required to be working in a role or have any planned service developments within which they will be able to prescribe after qualification. There is a greater opportunity for Trusts to filter their staff before entry to the course to ensure that they will be able to prescribe in their role.

In nursing in Northern Ireland, there is a local agreement that only nurses at G grade and above would be able to prescribe. This limits the ability of District Nurses and Health Visitors who are qualified to prescribe from a limited formulary as part of their postgraduate qualification but may be employed in a post lower than a G grade. Loss of confidence and competence to prescribe can be an issue for these nurses. It is important for a nurse prescriber to be competent to prescribe regardless of their grade.

Recommendation

- Further work is needed to explore;
  - The relevance of the local agreement that only nurses at G grade and above in light of the changes in legislation in independent nurse prescribing.

  - If the entry to training for non-medical prescribers can be prioritised to take account of future opportunities to prescribe.

A further list of barriers and challenges are listed in Appendix 1.

7 Conclusion

The working group considers that the need to address the three main issues outlined above is fundamental to the success of non-medical prescribing in order to underpin service developments in primary and community health care settings. If these issues are not addressed, the growth in non-medical prescribing will continue to be slow and the potential for the benefits outlined at the beginning of the paper will not be realised.

8 References

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6. Brown W & McDermott J (2005) Non-medical prescribing in an outpatient setting: renal services. Nurse Prescribing 3(1) 210-216.

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Appendix 1

Challenges / Barriers / Constraints

- Wider knowledge / understanding of non-medical prescribing among patients, professionals and staff
- Resistance to prescribing - It was noted that initially there was no choice for District Nurses / Health visitors on whether or not to participate.
- Patient understanding / acceptance of non-medical prescribing – particularly where collection / delivery of prescriptions services are widely used by patients on repeat medication
- Legislation – there is a time lag in changes to legislation in NI compared to England. This also applies to changes in the Drug Tariff and formulary and can cause confusion
- There are differences within the 4 jurisdictions and the differences not reflected in literature to support non-medical prescribers (NPC)
- Lack of information on non medical prescribing on the DHSS&PSNI website. There is more information on DOH website but it does not reflect the differences between NI and England.
- The NPF is out of date quickly and only re-issued every two years. The BNF contains the NPF and is issued twice a year. If the BNF was issued to all prescribers there would be better access to more up to date information. However there would be a significant cost implication.
- Lack of understanding of Drug Tariff
- The nurse prescribing coordinator role in Trusts has never been defined and came in addition to existing role.
- There is a lack of sufficient dedicated resources to support non-medical prescribing.
- There is confusion about the role of Staff in Boards / Trusts to provide support to staff who are non-medical prescribers
- There is variable / perceived lack of support from medical colleagues leading to local difficulties for staff including accessing appropriate mentorship
- There has been recent negative publicity from medical colleagues to announcement that BNF will be available to independent nurse and pharmacist prescribers
- There is sometimes a lack of willingness to challenge status quo within service developments