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Improving Patients' Access to Medicines:

A Guide to Implementing Nurse and Pharmacist Independent Prescribing within the HPSS in Northern Ireland

December 2006

Contents

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This document is adapted from guidance produced by the Department of Health in England in April 2006 titled *'Improving Patient's Access to Medicines: A Guide to Implementing Nurse and Pharmacist Independent Prescribing within the NHS in England.'*

It was developed and edited by Oriel Brown, Nurse Prescribing Advisor (EHSSB), Cathy Harrison, Principal Pharmaceutical Officer (DHSSPS), Rose McHugh, Nurse Prescribing Advisor (NHSSB), Angela McLernon, Nursing Officer (DHSSPS) and Gillian Plant, Nurse Prescribing Advisor (WHSSB).

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Foreword to Independent Nurse & Pharmacist Prescribing

I am delighted to advise that legislation is now in place to facilitate the expansion of Nurse Independent Prescribing and to introduce Pharmacist Independent Prescribing to Northern Ireland.

As healthcare professionals increasingly take on new roles and responsibilities, the ability of Nurses and Pharmacists to comprehensively prescribe will further improve services for patients. This is significant in relation to the modernisation and reform of services and as a mechanism to improve the accessibility of medicines to patients.

In Northern Ireland nurse prescribers are already prescribing in primary care, community and acute settings, however, the restricted extended formulary has limited the ability of some nurses to prescribe within their clinical areas. The new legislation will allow prescribing of all drugs in the BNF, including for nurse prescribers some controlled drugs. This will provide greater scope for patient management utilising the skills and resources of a wider range of health practitioners particularly in Chronic Disease Management, Medicines Management, Mental Health, Palliative Care and Dermatology.

The enclosed guidelines have been developed to support professional staff and employers to take forward this initiative to the benefit of patients and service users and should be used to further develop governance frameworks to ensure the delivery of safe and effective care.

My gratitude is extended to all the professionals involved in the development of this guidance which I now commend to you.

Paul Goggins, MP
Minister for Health, Social Services and Public Safety

How To Use The Guide

This guide has been prepared for:

- Health and Personal Social Services Trusts (HPSS) - Hospital and Community
- Area Health and Social Services Boards
- General Practitioners
- Community Pharmacists
- School of Pharmacy, Queens University Belfast
- School of Nursing and Midwifery, Queens University Belfast
- School of Nursing, University of Ulster
- Northern Ireland Centre for Post-graduate Pharmaceutical Education and Training (NICPPET)
- Northern Ireland Practice and Education Council for Nursing & Midwifery (NIPEC)
- Prescribing Advisors

This guide refers to existing organisational structures in NI. Organisational changes as a result of the Review of Public Administration will inform future arrangements in relation to roles and responsibilities.

Initially, it will be for Area Health and Social Services Boards and HPSS Trusts to consider, in light of local priorities, which nurses and pharmacists in their area should undertake the training programme for independent prescribing. This guide has been prepared to assist them. Copies of all or part of the Guide may be reproduced at local level as required.

The guidance will also be of interest to the Prison Healthcare Service, the Hospice Movement and the independent healthcare sector.

Introduction

1. This guide sets out the administrative and procedural steps needed to enable the following healthcare professionals in Northern Ireland to act as independent prescribers:

    - Registered nurses (first level)
    - Registered specialist community public health nurses/specialist
    - Registered midwives and
    - Registered pharmacists,

2. It provides information and advice on good practice for independent prescribers. This guide applies to all the professions listed above. (NB Where the term 'nurse' is used throughout the remainder of this document it includes midwives and specialist community public health nurses). It should be used with the NMC standards of proficiency for nurses and midwife prescribers.

3. This guide is not directly applicable to community practitioner nurse prescribers (formerly known as district nurse/health visitor prescribers) as their prescribing is limited to items from the Nurse Prescribers' Formulary for Community Practitioners.

Scope of this guidance and effect of devolution

4. Medicines legislation permits the introduction of independent prescribing across the United Kingdom and this guide refers specifically to how it will be implemented in Northern Ireland.

5. This guide has been produced to help promote safe and effective prescribing by nurse and pharmacist independent prescribers and is applicable to both the Health and Personal Social Services (HPSS) and the Independent Sector.

A Definition of Independent Prescribing

Definition of independent prescribing

6. The 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'.

7. 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 these elements 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. However, this should not limit other models of good practice developed to achieve the aims of paragraph 12.

Legal basis of independent prescribing by nurses and pharmacists

8. The legislative history showing the changes which occurred to enable the introduction of nurse and pharmacist prescribing in the UK and Northern Ireland is explained in detail in Annex A.

9. Independent prescribing by nurses and pharmacists was enabled when the UK wide, Medicines and Human Use (Prescribing) (Miscellaneous Amendments) Order was changed in May 2006 and further amendments to regulations put these changes into effect in Northern Ireland in August 2006.

10. The new legislation allows nurses who have successfully completed a nurse independent prescribing course (formerly known as an extended formulary nurse prescribing course) approved by the NMC to prescribe any licensed medicine (i.e. products with a UK marketing authorisation) for any medical condition, including some Controlled Drugs (see Annex B). Nurse Independent Prescribers must only ever prescribe within their own level of experience and competence, acting in accordance with Clause 6 of the Nurse and Midwifery Council's (NMC) code of professional conduct: standards for conduct, performance and ethics'.

11. Legislation also allows qualified Pharmacist Independent Prescribers to prescribe any licensed medicine for any medical condition, with the exception of all Controlled Drugs, until such time as there are changes to the Misuse of Drugs Regulations (Northern Ireland) 2002. Pharmacist Independent Prescribers must only ever prescribe within their own level of experience and competence and the Pharmaceutical Society of Northern Ireland (PSNI) have asked prescribers to refer for guidance to 'Medicines, Ethics and Practice - Code of Ethics and Standards Service Specification for Pharmacist Prescribers' (Annex C), published by the Royal Pharmaceutical Society of Great Britain (RPSGB) as the 'Ethics and Practice A Guide for Pharmacists in Northern Ireland' is currently being updated in respect of pharmacist prescribing.

Aims of independent prescribing by nurses and pharmacists

12. It is Government policy to extend prescribing responsibilities to non-medical professions to:

- improve patient care 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 and
- contribute to the introduction of more flexible team working across the HPSS.

13. Employing organisations should develop a strategic plan for the use of non-medical prescribing to include independent prescribing by nurses and pharmacists. Typically this would involve senior managers, user groups and clinicians (doctors, nurses, pharmacists) and the drug and therapeutics committee (or equivalent). The plan should be approved at management board level and would, for example:

- develop mechanisms to identify nurses and pharmacists for whom non-medical prescribing training would be appropriate;
- 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;
- identify funding for non-medical prescribing and ensure appropriate distribution, management and monitoring of such funding.

Implementation Strategy

Which nurses, midwives and pharmacists can act as independent prescribers?

14. A Nurse Independent Prescriber must be a first level registered nurse, registered midwife or registered specialist community public health nurse whose name in each case is held on the NMC register, with an annotation signifying that the nurse has successfully completed an NMC approved programme of preparation and training for nurse independent prescribing.

15. A Pharmacist Independent Prescriber must be a registered pharmacist whose name is held on the membership register of the PSNI, with an annotation signifying that the pharmacist has successfully completed an education and training programme accredited by the PSNI and is qualified as an independent prescriber.

Selection of nurses, midwives and pharmacists to train

16. The selection of nurses and pharmacists who will be trained as independent prescribers is a matter for employing and or commissioning organisations who are best placed to assess local service and patient needs. 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(s) in which they will prescribe should also have been identified before they begin training to prescribe. This will almost certainly be in the field in which they already hold considerable expertise.

17. The NMC standards of proficiency for nurse and midwife prescribers states that, in addition to fulfilling the legal criteria for eligibility to prescribe, applicants who are selected for prescribing training will need to meet the following requirements.

- nurses should have the ability to study at Level 3 (degree level).
- nurses must, as per NMC standards have at least three years' post-registration clinical nursing experience, of which the year immediately preceding their application to the training programme should be in the clinical area in which they intend to prescribe;

- Where the registrant is not undertaking a training module in diagnosis and assessment they must be assessed by their employers as being competent to take a history, undertake a clinical assessment and make a diagnosis before being put forward for training. 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 and the medicines which will be effective that make a proficient and competent prescriber.

18. Pharmacists are already educated at degree level and therefore have the ability to study at a minimum of Quality Assurance Agency (QAA) for Higher Education level 3.
Pharmacists should have at least two years experience practising as a pharmacist in a clinical environment, in a hospital or a community setting, following their pre-registration year after their graduation. Organisations who put forward pharmacists for independent prescribing should assure themselves that the pharmacist is competent to prescribe in the area in which they will prescribe following training.

19. A designated medical practitioner (DMP) will need to be selected who is willing and able to contribute to and supervise the nurse or pharmacist's learning in practice element of their training. In time a DMP could be an experienced nurse or pharmacist independent prescriber

20. It is also necessary that the applicant has the support of their employer to confirm that:
    - their post is one in which they will have the need and the opportunity to act as an independent prescriber immediately upon qualifying;
    - there is a local need for them to prescribe. (HPSS Trusts and Boards will decide whether there is a local need for staff to access prescribing training. Nurses and pharmacists should not be able to undertake HPSS funded training unless there has been prior agreement about the therapeutic area in which they will prescribe).
    - for nurses and pharmacists in primary care, they will have access to a budget to meet the costs of their prescriptions on completion of the course;

- they will have access to continuing professional development (CPD) opportunities on completion of the course;
- they will work within a robust clinical governance framework. - good practice examples of non-medical prescribing clinical governance frameworks are given in Appendix 1;
- the student will be supported during their training, allowed some flexibility for self-directed study and provided with the required time to undertake study and develop competence.

21. There are likely to be many nurses and pharmacists 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 HPSS in terms of quicker and more efficient access to medicines for patients and
    - better use of the professional's skills.

    The individual practitioners must also understand and accept the higher level of clinical responsibility associated with prescribing.

22. The non-medical prescribing lead in commissioning bodies (currently Boards) should liaise with HPSS employers and Higher Education Institutions (HEI), to ensure that applicants and the number of course places can be appropriately matched. Stakeholders may find it helpful to work together to agree priorities for access to prescribing courses.

23. The Northern Ireland Practice and Education Council (NIPEC) have produced a Development Framework (df) document that contains tools and guidance to support practitioners and managers to develop new roles or change existing roles significantly. The df document can be downloaded from the NIPEC website at www.nipecdf.org.

Commissioning services

24. Pharmacist and Nurse Independent Prescribers will give GP practices, HPSS Boards and Trusts, and all who commission services the opportunity to change the way they provide services to patients. A wider range of professionals who can act as independent prescribers provides a wider range of skills and expertise from which to draw, to meet patient needs. Using nurse and pharmacist independent prescribers can, amongst other things, help:
    - fill geographical or skills gaps in services;

- meet the needs of patient groups who find it hard to access services, e.g. housebound people, people with busy lifestyles, vulnerable groups;
- manage long-term conditions;
- manage co-morbidities / complex medication regimes;
- improve access to medicines.

Training Provision

25. Training will be provided through HEI at the University of Ulster for nurses and through the Northern Ireland Centre for Post Graduate Pharmaceutical Education and Training (NICPPET) at Queens University Belfast for pharmacists. Appropriate commissioning arrangements will be put in place to ensure the delivery of qualified nurse and pharmaceutical practitioners.

26. Employers will be required to facilitate their staff in accessing training.

Conflicts of interest

27. In nominating for training any nurses or pharmacists whose posts are directly or indirectly funded by pharmaceutical and other companies, employers should be aware of, and take necessary steps to ensure that there are no conflicts of interest that may subsequently arise in the nurse's or pharmacist's practice.

28. Nurses are reminded of section 7.2 in the NMC Code of Professional Conduct which states that, in the exercise of his/her 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'.

29. Principle 1 of the PSNI Ethics and Practice, A Guide for Pharmacists in Northern Ireland 1997 states that, 'A pharmacist's prime concern must be for the welfare of both the patient and other members of the public.' Obligation 1.1 provides this additional guidance, 'A pharmacist must at all times act in a manner which promotes and safeguards the interests of the public, justifies public trust in that pharmacist's knowledge, ability and judgement and enhances the good standing and reputation of the profession'.

30. Principle 2 of the PSNI Ethics and Practice, A Guide for Pharmacists in Northern Ireland 1997 states that 'A Pharmacist must uphold the honour and dignity of the profession and not engage in any activity which may bring the profession into disrepute'. Obligation 2.1 provides this additional guidance 'A pharmacist must have due regard for the reasonably accepted standards of behaviour both within and outside his professional practice.'

31. If local organisations conclude that there is no conflict of interest, then the supported individual should openly declare and record this through local corporate governance mechanisms.

32. HPSS organisations should bear in mind issues of potential conflict of interest when they are considering commercial sponsorship of events aimed at prescribers.

33. In a situation where it has been agreed that a prescriber sponsored by a pharmaceutical company or associated agency can act as an independent prescriber, his/her prescribing should be periodically audited to ensure probity of action.

Chapter 4

Education and Training programmes for independent prescribing

34. The NMC have published Standards of Proficiency for Nurses and Midwives and it will be necessary for existing and new training programmes to be validated against these standards from September 2007 available at www.nmc-uk.org.

35. The PSNI have endorsed a curriculum for pharmacists to become independent prescribers, and are responsible for accrediting courses for pharmacists provided by recognised providers. Only successful completion of programmes approved by the NMC or PSNI will lead to registration as a Nurse or Pharmacist Independent Prescriber.

36. Programmes for nurse and pharmacist independent prescribing are developed by the education programme provider and approved by the NMC and PSNI respectively. The DHSS&PS expects course validators to approve only those courses that demonstrate content that is consistent with published guidance and that the learning outcomes of the curricula are to be achieved.

37. Nurses training to become nurse prescribers will undertake a specific programme of preparation at a minimum of degree level (level three). This enables a nurse to qualify as both a Nurse Independent Prescriber and as a Nurse Supplementary Prescriber. The programme comprises a minimum of 26 days at a Higher Education Institution plus a minimum of 12 days 'learning in practice', during which a supervising DMP will provide the student with supervision, support and opportunities to develop competence in prescribing practice. The nurse will also need to undertake an element of self-directed learning.

    The programme of training and preparation should be completed within one academic year. In exceptional circumstances only, a registrant may complete their course within a two year period. NMC Standards state that, if a registrant does not complete all assessments within this time they must undertake the whole programme and all assessments again. (NMC section 1 standard 3).

38. Pharmacists training to be Pharmacist Independent Prescribers will undertake a specific programme of training at least at QAA level three (degree level), in

accordance with the PSNI curriculum. As with nurses, this will enable them to qualify as both a Pharmacist Independent Prescriber and as a Pharmacist Supplementary Prescriber. The Northern Ireland Centre for Post Graduate Pharmaceutical Education Training (NICCPET) plan to offer a postgraduate certificate in independent prescribing from 2007 in a training programme comprising of a minimum of 26 days training (approximately 8 day workshops and 18 days distance learning), plus a minimum of 12 days in-practice training.

39. Pharmacists who have already trained as supplementary prescribers will be able to apply to NICCPET to complete a conversion course to train as independent prescribers. When accredited the conversion course will consist of a two day workshop plus a minimum of two days in-practice with a DMP.

40. In addition to the time spent on the formal programme, it is important that employers of nurses and pharmacists undertaking the programme should recognise the demands of private study and provide support where necessary to ensure that the student is provided with the required time to undertake study and develop competence. Employers should also consider providing buddying/mentoring opportunities for these nurses and pharmacists.

41. The training programmes include an assessment of theory and practice, all elements of which must be passed before the practitioner's entry on the NMC/PSNI register is annotated, to indicate that he/she holds a qualification for independent prescribing.

Supervising/Designated Medical Practitioner (DMP)

42. 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 help to inform the selection of DMP.

43. The period of learning in practice 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 certain competencies. Normally, these outcomes and competencies will be identified by the HEI running individual courses.

44. The DMP has a critical and highly responsible role in educating and assessing the non-medical prescriber and assuring competence in prescribing.

45. 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.

46. The approach to teaching and learning will be developed on an individual basis between the DMP and the trainee.

'Buddying' schemes during training

47. It is unlikely that a trainee will need to spend all of the period of learning in practice with their DMP, as other clinicians may be better placed to provide some of the learning opportunities. However, the DMP remains responsible for assessing whether all of the learning outcomes have been met. Some form of 'buddying' link may also be valuable, for instance, with a current nurse or pharmacist prescriber, or with a senior experienced nurse or pharmacist.

Continuing Professional Development (CPD)

48. All nurses and pharmacists have a professional responsibility to keep themselves abreast of clinical and professional developments. This is no less true for Nurse and Pharmacist Independent Prescribers who 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.

49. 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 nurse 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.

50. For pharmacists, the PSNI's new statutory requirements for CPD will require pharmacist prescribers to demonstrate CPD in their area of prescribing practice. The employer should ensure that the pharmacist has access to relevant education and training provision. It is good practice for employers to support pharmacist prescribers in pursuing self-directed study.

51. The National Prescribing Centre publish frameworks for maintaining competency in prescribing for nurses and pharmacists on their website at: www.npc.co.uk

'Buddying'/mentor post - qualification

52. 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 to prescribe. This could be a doctor, nurse or pharmacist and is a sensible way of enhancing CPD. Supplementary Prescribing is also a useful mechanism to enable new non-medical prescribers to develop their expertise and confidence in prescribing.

Chapter 5

Medicines Prescribable

53. Advice on prescription forms and prescribing is detailed in Annex D.

Controlled Drugs

54. Nurse Independent Prescribers may prescribe any licensed medicine (i.e. products with a UK marketing authorisation) for any medical condition, including a limited list of Controlled Drugs solely for specific medical conditions as detailed in Annex B. This list is also available in the NI Drug Tariff (part IXC) and in the September 2006 edition of the BNF.

55. Pharmacist Independent Prescribers may prescribe any licensed medicine (i.e. products with a UK marketing authorisation) for any medical condition, with the exception, at present, of all Controlled Drugs. This does not affect pharmacists' ability to sell some Schedule 5 Controlled Drugs.

Prescribing within competence

56. All Nurse and Pharmacist Independent Prescribers must work within their own level of professional competence and expertise, and must seek advice and make appropriate referrals to other professionals with different expertise. Nurses and pharmacists are accountable for their own actions, and must be aware of the limits of their skills, knowledge and competence.

57. Care needs to be exercised in simply delineating individual therapeutic areas for prescribing, given that many patients have co-existing morbidities and are using multiple therapies. It is therefore important that the prescriber has a competent knowledge of co-morbidities and treatments in order to effect optimal theraputic care.

58. Nurses must act within clause 6 of the NMC 'Code of professional conduct: standards for conduct, performance and ethics' available at www.nmc-uk.org

59. Pharmacists must act within the PSNI's 'Ethics and Practice, A Guide for Pharmacists in Northern Ireland 1997'.

Prescribing licensed medicines for unlicensed uses, so-called 'off-label'

60. Nurse and Pharmacist Independent Prescribers may prescribe medicines independently off-licence or off-label ie:-for uses outside their licensed indications/UK marketing authorisation. Definitions of these terms are given in Annex E. They must however, accept professional, clinical and legal responsibility for that prescribing, and should only prescribe 'off-licence' where it is accepted clinical practice.
61. A local policy for the use of off-licence medicines should be approved through mechanisms such as drug and therapeutic committees or the equivalent. 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.

Unlicensed medicines (products without a UK marketing authorisation)

62. Nurse and Pharmacist Independent Prescribers are not permitted to prescribe unlicensed medicines.

Borderline Substances

63. All health service prescribers will need to abide by the terms of service of the organisation under which they operate. For example, if operating under new GMS, borderline substances may be prescribed but the prescription will need to be marked 'ACBS'. A list of Advisory Committee of Borderline Substances (ACBS) approved products and the circumstances under which they can be prescribed, can be found in part X of the Drug Tariff. Although this is a non-mandatory list, Nurse and Pharmacist 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 / Dressings in Part III of the NI Drug Tariff

64. Nurse and Pharmacist Independent Prescribers may also prescribe any appliances or dressings that are listed in Part III of the NI Drug Tariff. Nurses and pharmacists prescribing in secondary care are not restricted to prescribing appliances/dressings from part III of the NI Drug Tariff, but should take into account local formulary policies and the implications for primary care.

Chapter 6

Clinical & Social Care Governance

65. Clinical and social care governance is the system through which HPSS organisations are accountable for continuously improving the quality of their services and safe guarding high standards of care, by creating an environment in which clinical excellence will flourish.

66. Chief Executives are legally accountable for the quality of care that patients receive and for securing patient safety.

67. All employing organisations must ensure that nurse and pharmacist independent prescribing is included within their overall clinical governance framework, to ensure that nurses and pharmacists practice safely and competently. The framework must include systems for the following.
    - 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 practice. This will usually include evidence that they have appropriate specialist knowledge and an opportunity to prescribe within their work.
    - 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 training programme.
    - Ensuring that the names of prescribers are annotated on their professional register, before they begin to prescribe. This should be ascertained via the usual register checking arrangements that are undertaken for new employees, as detailed in Chapter 12.
    - Ensuring arrangements are in place for assessment of practice, clinical supervision, audit, and continuing professional development for all Nurse Independent Prescribers and Pharmacist Independent Prescribers.
    - Developing a risk management plan - this will ensure that potential risks associated with extending clinical practice are recognised and minimised.
    - Ensuring that the parameters of an individual's prescribing are agreed between the prescriber, their manager or local professional lead and their employer.

- Ensuring that drug and therapeutic committees are aware of the medicines being prescribed by Nurse and Pharmacist Independent Prescribers.

68. Nurses and pharmacists should use clinical supervision arrangements or equivalent as an opportunity for reflection on prescribing, as well as other aspects of practice. The model of clinical supervision should be agreed at local level, taking account of other staff support mechanisms and resources.

69. Peer review, support and mentoring arrangements should be established for nurses and pharmacist prescribers. Audits, clinical governance arrangements and CPD requirements will allow them to reflect on their prescribing practice. Examples of good practice for non-medical prescribing clinical governance frameworks are detailed in Appendix 1.

70. A review of independent prescribing by nurses and pharmacists should be carried out as part of the overall prescribing monitoring arrangements and should be considered as a suitable area of practice for regular audit. This could include prescription and cost data available from the Central Services Agency (CSA) and from hospital internal systems.

Independent/Private sector

71. Nurse and Pharmacist Independent Prescribers who work outside HPSS 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 practice. 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. Regulation and Inspection bodies for the independent/private sector should consider how they will monitor that this is undertaken.

Good Practice, Ethics and Issues

Responsibility for prescribing decisions

72. A Nurse or Pharmacist Independent Prescriber can only order a medicine for a patient whom he/she has assessed. In primary care, a nurse or pharmacist should only write prescriptions on a prescription pad bearing his/her own unique NMC/PSNI registration number, as detailed in Annex D.

Informing patients

73. Nurse and Pharmacist Independent Prescribers must ensure that patients are aware that they are being treated by a non-medical practitioner. Where the management of the patient's care is outside the scope of the prescriber the patient should be referred to the appropriate healthcare professional.

Prescribing for self, family and friends

74. Nurse and Pharmacist Independent Prescribers must not prescribe any medicine for themselves. Neither should they prescribe a medicine for anyone with whom they have a close personal or emotional relationship, other than in an exceptional circumstance. (as detailed in the NMC's 'Standards at www.nmc.co.uk and the RPSGB's 'Medicines, Ethics and Practice - Code of Ethics and Standards Service Specification for Pharmacist Prescribers' in Annex C.)

Gifts and benefits

75. The advertising and promotion of medicines is strictly regulated under the Medicines (Advertising) Regulations 1994, and it is important that Nurse and Pharmacist 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.

76. 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. HPSS 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.

77. 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's self-regulatory body, the Prescription Medicines Code of Practice Authority.

Guidance on Controlled Drugs

78. The Home Office's Misuse of Drugs Act and associated regulations govern the prescribing of Controlled Drugs. For guidelines on the prescription of Controlled Drugs, healthcare professionals should refer to:

- guidance from their respective professional bodies;
- letters issued from DHSS&PS to health professionals in relation to changes to the Misuse of Drugs act 1972. The letters dated, 03/01/06, 16/05/06 and 26/06/06 and future letters can be viewed on dhsspsni.gov.uk.
- the legal requirements for prescriptions for Schedule 2 and 3 Controlled Drugs are summarised in the British National Formulary, the PSNI publication, 'Ethics and Practice: A Guide for Pharmacists in Northern Ireland' and also in part XVIIB of the Drug Tariff.

Chapter 8

Patient Records: Access and Updating

79. 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 (although for guidance, staff should refer to the standards published by the relevant professional/regulatory body), but a good record is one that provides in a timely manner all professionals involved in a patient's treatment, with the information needed 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 pre-requisite for promoting safe and effective care for patients.

80. Best practice suggests that the details of any prescription, together with other details of the consultation with the patient, should be entered onto the shared patient record immediately, or failing that, 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 or pharmacy patient record (where a separate record exists). (NMC standards of proficiency for nurse and midwife prescribers, section 2 standard 7).

81. For pharmacist independent prescribers working in the community, it will be necessary to ensure that the facility is available to populate a patient's record. In this regard the development of integrated IT sytems is essential.

82. It is recommended that the record indicates clearly:
    - the date of the prescription;
    - the name of the prescriber (and that they are acting as a Nurse or Pharmacist Independent Prescriber) and
    - the name of the item prescribed, together with the quantity, dose, frequency and treatment duration).

83. To aid safe administration of medicines, the record should also 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, 5mls to be taken every four hours by mouth as required for pain, maximum of 20mls in any 24 hours'.

84. 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 Sales List and Pharmacy medicines provided 'over the counter' is also recorded.

Adverse Drug Reaction Reporting

MHRA/CHM Yellow Card Scheme

85. 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 (ADR). The MHRA/CHM encourage the reporting of all suspected ADRs 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 ADRs to all other established medicines, 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. The electronic Yellow Card provides a simple and fast way to report suspected ADRs. 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 ADRs using this method, although hard copy Yellow Cards are also acceptable (and can be found bound to the back of the British National Formulary). Patients, parents, carers etc can also report suspected ADRs using the above methods and there is also a freephone number - 0808 100 3352, that can be used.

86. 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 also available from the MHRA's website, www.mhra.gov.uk .

Adverse incident reporting

87. If a patient suffers harm due to an adverse incident involving medicines, or if harm could have been caused to the patient by the medicine (a near miss), the incident or near miss should be reported by the Nurse or Pharmacist Independent Prescriber using the reporting system of the health organisation by whom they are employed.

Legal and Clinical Liability

Liability of prescriber/Professional indemnity

88. Prescribers are accountable for all aspects of their prescribing decisions. They should therefore only prescribe those medicines they know are safe and effective for the patient and the condition being treated. They must be able to recognise and deal with pressures (e.g. from the pharmaceutical industry, patients or colleagues) that might result in inappropriate prescribing.

89. All prescribers are recommended that they should have sufficient professional indemnity insurance cover.

90. The NMC recommends that every nurse/midwife prescriber should ensure he/she has professional indemnity insurance, 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 for purpose. See clause 9 of the NMC code of professional conduct: standards for conduct, performance and ethics.

91. The PSNI's Ethics and Practice, A guide for Pharmacists in Northern Ireland standard 6.1 states that 'A pharmacist must either carry his own indemnity or work in an establishment which is covered by indemnity insurance or an equivalent arrangement for the protection of the recipients of the service provided by that establishment.' In addition standard 6.2 states 'A pharmacist owner, superintendent or manager in a hospital, responsible for the employment of other pharmacists must ensure that adequate professional indemnity arrangements are provided for all pharmacists working in the establishment.'

92. Both the employer and employee (or contractor) should ensure that the employee's job description (or contractor's agreed arrangements) includes a clear statement that prescribing is required as part of the duties of that post or service.

Liability of employer

93. Where a nurse, midwife or pharmacist 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 NMC for this aspect of their practice, as for any other, and must act at all times in accordance with the NMC Code of Professional Conduct. Pharmacist Independent Prescribers are individually accountable to the PSNI and must at all times act in accordance with the 'PSNI Ethics and Practice A guide for Pharmacists in Northern Ireland 1997' and the RPSGB 'Code of Ethics and Standards Service Specification for Pharmacist prescribers' (Annex C).

Nurse Prescribing and Administering / Supply of Medicines

Prescribing and administration / supply

94. NMC standards, practice standard 9 states that;

- Nurses must ensure separation of prescribing and administering activities whenever possible.
- In exceptional circumstances where a nusre is 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.

Dispensing of Independent Prescriber's Prescriptions

Dispensing Doctors in primary care

95. Where a GP practice is a dispensing practice, prescriptions from Nurse and Pharmacist 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.

96. Reimbursement for prescriptions written by Nurse and Pharmacist Independent Prescribers can be claimed by Dispensing Doctors.

Prescribing and dispensing by Nurse and Pharmacist Independent Prescribers

97. NMC standards practice standard 10 and Annex A of 'Medicines, Ethics and Practice - A guide for Pharmacists', published by the RPSGB state that prescribers must ensure that there is separation of prescribing and dispensing activities wherever possible. In exceptional circumstances, where a nurse or pharmacist is both prescribing and dispensing a patient's medication, a second suitably competent person should be involved in checking the accuracy of the medication provided.

98. Normally prescribing and dispensing activities are separate. However, in delivering the aims of paragraph 12, situations may occur where, prescribing and dispensing are carried out by the same individual. In such circumstances it is important that:

- clear accountability arrangements are in place to ensure patient safety and probity;
- there are audit and clinical governance arrangements in place, which can track prescribing and dispensing by Nurse and Pharmacist Independent Prescribers and
- where the two roles do co-exist, another person must carry out a final accuracy check and a check for clinical appropriateness should also be carried out.

Verification of Prescribing Status

Role of the pharmacist on verification of prescribing status

99. The dispensing pharmacist will need to be sure that the prescriber has qualified as a Nurse or Pharmacist Independent Prescriber.

100. The prescription form will indicate whether the prescriber is a Nurse or Pharmacist Independent Prescriber. The dispensing pharmacist will, of course, need to use his/her professional judgement, just as he/she does for doctors' prescriptions, to assess whether a prescription is appropriate for a particular patient.

101. To enable pharmacists to check whether a prescription handed in for dispensing is bona-fide, employing authorities should keep a list of all nurse and pharmacist prescribers employed by them and hold a copy of the prescriber's signature. Individuals should be prepared to provide specimen signatures to pharmacists, should that be required.

Nursing and Midwifery Council (NMC)

102. In the case of nurses, most enquiries from dispensing pharmacists will be resolved by telephoning the prescriber, or the employing authority.

103. The prescribing status of a nurse can be checked 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 it will confirm if someone has live registration and what type of prescriber they are.

Pharmaceutical Society of Northern Ireland (PSNI)

104. The PSNI register is annotated to indicate that the pharmacist is a supplementary prescriber and it is expected that a similar annotation will be recorded for independent prescribers. To check whether a prescription is bona fide, pharmacists should telephone the PSNI and ask to check a prescriber's status. Telephone 028 9032 6927 Mon - Fri 9.00am-5.00pm

Royal Pharmaceutical Society of Great Britain (RPSGB)

105. The RPSGB has on-line 24 hour web access at - www.rpsgb.org.uk/members/registration/mem.html/ , which provides a list of pharmacists registered either by name or registration number; the register is also annotated to indicate the pharmacist is a supplementary prescriber. It is expected a similar annotation will be recorded for Pharmacist Independent Prescribers. This enables 24-hour access and will incorporate an indicator of prescribing status.

Role of the CSA

106. The CSA checks only to ensure that a prescription written by a nurse or pharmacist is restricted to permitted items from the drug tariff. It does not check whether a nurse or pharmacist is prescribing as an Independent or Supplementary Prescriber.

Dispensing by Appliance Contractors

107. When a nurse or pharmacist becomes aware that the patient intends to have a prescription dispensed by an appliance contractor, he/she must ensure that the prescription does not contain medicinal preparations. Appliance contractors should follow the instructions on the Prescription Invoice - Form HS30 when sorting prescription forms prior to sending them to the CSA for pricing. NB Appliance contractors cannot dispense medicinal preparations.

Urgent dispensing

108. Occasionally a nurse or pharmacist prescription may require dispensing out of normal pharmacy opening hours. Many community pharmacies are now open out of hours, and the local Out Of Hours Services should have a list of those that do so. Hospitals and Out of Hours Services will have local arrangements for supplying medicines out of hours, which should be brought to the attention of all prescribers, including nurses and pharmacists.

Dispensing of items in England, Scotland and Wales.

109. Prescriptions written by Nurse and Pharmacist Independent Prescribers in Northern Ireland may be dispensed by pharmacists in England, Scotland and Wales and vice-versa.

Dispensing items against Nurse or Pharmacist Independent Prescriber's prescriptions in hospital pharmacies

110. An up-to-date list of all qualified Nurse and Pharmacist Independent Prescribers employed by the hospital will need to be kept in the hospital pharmacy. Pharmacy staff should check the prescriber against the list. The same process will apply for in-patient, outpatient and discharge prescriptions.

Monitoring independent prescribing information

111. The CSA reimburses costs to dispensing contractors and provides essential information electronically and provides paper copies to authorised users. Prescribing by Nurse Independent Prescribers will be identifiable using Northern Ireland Nurse Analysis (NINA) reports. Prescribing reports for

independent pharmacist prescribing have yet to be established. Health Boards will be expected to provide routine data analysis of all prescribing which will include analysis of cost effectiveness and quality. Independent Prescribers can expect to receive information via their employing Health Board, GP Practice or Out-of-Hours Care Provider to monitor their prescribing.

112. Typically, the hospital pharmacy department will monitor prescribing, and provide feedback on all prescribing in hospitals to both clinicians and managers.

113. The route for accessing prescribing data for non-medical prescribers depends on where their prescribing costs are allocated.

Annex A - History of non-medical Prescribing

1. Nurse Prescribing has been on the health agenda since 1986 when the Cumberledge Report, "Neighbourhood Nursing - A Focus for Care" recommended that community nurses should be able to prescribe, as part of their everyday nursing care, from a limited list of items. In 1989 The Crown Report, 'Report of the Advisory Group on Nurse Prescribing' endorsed nurse prescribing and highlighted the circumstances in which nurse prescribing could occur. A successful private members bill led to the primary legislation (The Medicinal Products: Prescription by Nurses etc. Act, 1992) that provided the power for nurse prescribing.

The current nurse prescribing scheme is based on the recommendations contained in The Crown Report, 1989, which advised Ministers on how nursing care in the community might be improved by the introduction of 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 and
- clarification of professional responsibilities leading to improved communications between team members (DOH,The Crown Report, 1989)

Following the introduction of the necessary legislation, nurse prescribing was first piloted in eight GP fundholding practices in England in 1994, extended to a whole district community HPSS Trust in 1996 and to further community trusts in each of the remaining regions in England in 1997. The evaluation report on nurse prescribing in January 1997 found that nurse prescribing had a number of benefits for patients, carers, GPs, nurses and other health professionals.

2. To take nurse prescribing forward in Northern Ireland, a steering group was established in August 1997 with relevant professional representatives from within the DHSS&PS, and HPSS Boards and Trusts. The initial phase of implementation of nurse prescribing in Northern Ireland involved the establishment of five sites in May 1998 to test out the administrative processes required. A phased rollout commenced in April 1999 and was completed by December 2001.

3. The statutory Instruments which facilitated the implementation of nurse prescribing are:

- the Medicine Act 1968;
- the Health and Personal Social Services (Northern Ireland) order 1972;
- the Medicinal Products; Prescription by Nurses etc. Act 1992;
- the Pharmaceutical Services (Northern Ireland) Order 1992
- the Pharmaceutical Services (1992 Order) (Commencement) Order (Northern Ireland) 1997
- the Pharmaceutical Services Regulation (Northern Ireland) 1997.

Following a successful pilot programme, the Department of Health introduced nurse prescribing nationally for District Nurses and Health Visitors in England from December 1998 (Northern Ireland in 1999). The Nurse Prescribers' Formulary for Community Practitioners (until 2005 called the Nurse Prescribers' Formulary for District Nurses and Health Visitors) enabled Community Practitioner Nurse Prescribers to prescribe from a formulary of appliances, dressings and some medicines for patients in the community.

Extending nurse prescribing

4. Following a 3 month UK wide consultation with nursing, medical and pharmacy professional organisations from October 2000, Ministers announced in May 2001 that nurse prescribing would be extended to more nurses and to a wider range of medicines, to cover four broad areas of practice:

- minor ailments;
- minor injuries;
- health promotion and
- palliative care.

5. The extension is 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 is that patient safety is paramount.

6. Following training, nurses prescribing under this extended scheme were able to prescribe all General Sales List and Pharmacy medicines currently prescribable by GPs under GMS and pharmaceutical services regulations, with the exception of those products which contain controlled drugs. They were also able to prescribe from a list of Prescription Only Medicines (POMs).

7. 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. This form of prescribing is likely to be particularly suitable for nurses working with patients with enduring conditions such as asthma, diabetes, heart disease or mental illness.

8. The University of Southampton completed an evaluation of nurse prescribing for the Department of Health early in 2005. The evaluation concluded that the limits of the Extended Formulary were 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 clinical management plan agreed with a doctor.

9. 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 prescribing by nurses.

13. 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, as well as a faster and more accessible service.

14. In October 2005, the Committee on Safety of Medicines considered the responses to both consultations and recommended to Ministers that suitably trained and qualified nurses and pharmacists 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.

15. Changes to regulations from May 2006 in England and subsequent changes in Northern Ireland enabled suitably trained nurses and pharmacists to qualify as independent prescribers, who will then be able to prescribe any licensed medicine (i.e. products with a valid marketing authorisation (licence) in the UK) including some Controlled Drugs for specified medical conditions. At present Pharmacist independent prescribers cannot prescribe Controlled Drugs,

although this could change in the future. Nurse Independent Prescribers can prescribe a limited range of Controlled Drugs for specific medical conditions.

Comparison with Nurse Prescribers' Formulary for Community Practitioners, and Supplementary Prescribing

16. Following training incorporated into their specialist practitioner programmes, Community Practitioner Nurse Prescribers (formerly District Nurse and Health Visitor prescribers) can prescribe from the Nurse Prescribers' Formulary for Community Practitioners (formerly the Nurse Prescribers' Formulary for District Nurses and Health Visitors). This Formulary includes dressings, appliances and a limited number of medicines relevant to community nursing and specialist community public health nursing practice.

17. Supplementary Prescribers (nurses, pharmacists, physiotherapists, radiographers, chiropodists/podiatrists and optometrists) can prescribe in partnership with a doctor (or dentist). Nurse and pharmacist supplementary prescribers are able to prescribe any medicine, including Controlled Drugs and unlicensed medicines that are listed in an agreed Clinical Management Plan. All supplementary prescribers may prescribe for any medical condition, provided that they do so under the terms of a patient-specific Clinical Management Plan (CMP) agreed with a doctor.
The Plan will be drawn up, with the patient's agreement, following diagnosis of the patient. Supplementary prescribing may well still be the most appropriate mechanism for prescribing, for instance where a nurse or pharmacist is newly qualified as a prescriber or where a team approach to prescribing is clearly appropriate, or where a patient's Clinical Management Plan includes certain Controlled Drugs.

Annex B - Controlled Drugs

Nurse Independent Prescribers can prescribe any licensed medicine for any medical condition, including 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;

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 hydrochlorid	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

Annex C RPSGB - Code of Ethics and Standards Service Specification for Pharmacist Prescribers

Before prescribing, pharmacists must successfully complete an education and training programme accredited by the Society and must register with the Society as a pharmacist prescriber. Pharmacists must only prescribe within the limits of their registration and must comply with the statutory requirements applicable to their prescribing. Pharmacists have an obligation to prescribe responsibly and in their patient's best interests and must:

a) prescribe within the limits of their professional expertise and competence
b) not prescribe for themselves, or for anyone with whom they have a close personal or emotional relationship, other than in an emergency
c) make an appropriate assessment of the patient's condition and only prescribe to meet the patient's genuine clinical needs
d) prescribe only where they have an adequate knowledge of the patient's health and medical history
e) be aware of and give consideration to local and national prescribing guidelines
f) keep accurate comprehensive records of their consultation and prescribing for an individual patient
g) communicate effectively with other practitioners involved in the care of the patient
h) refer the patient to another practitioner when it is necessary to do so
i) prescribe in accordance with a patient's individual clinical management plan when prescribing as a supplementary prescriber. Refer the patient back to the independent prescriber when their circumstances fall outside the clinical management plan
j) ensure separation of prescribing and dispensing whenever possible. Where a pharmacist is both prescribing and dispensing a patient's medication a second suitably competent person should normally be involved in the checking process.

(October 2005)

Annex D - Prescribing Information

Notification of prescriber details to the Central Services Agency

1. The details of Primary Care Nurse or Pharmacist Independent Prescribers must be registered with Central Services Agency (CSA) before prescriptions for that prescriber can be ordered. There is currently no requirement to notify CSA of changes to the details of hospital-based prescribers.

2. Notification of required details by the prescribers' employer to the CSA enables the setting up of automatic monitoring processes, as well as allowing the provision of prescriber details to the supplier (currently De la Rue Smurfit) for the printing of prescription pads.

3. Employers of all Nurse and Pharmacist Independent Prescribers practising in primary care are therefore required to inform the CSA of the individual Nurse or Pharmacist Independent Prescriber's details - using the CSA electronic registration database.

4. The CSA Registration database should also be used to notify any changes in circumstances (e.g. name, telephone number) as they occur. Changes to prescriber details should be reported to CSA via the electronic registration database;

5. Changes to prescriber details in hospital should be reported to the nurse prescribing co-ordinator.

Prescription Forms

6. All prescription forms require information to be entered on them (by printing or writing or a combination of both). In addition to the correct dispensing of the items prescribed, this allows for prescribing information and costs to be attributed to the correct prescriber and / or organisation, as well as to the correct prescribing budget.

PRESCRIBING IN PRIMARY CARE

7. Employers should note that prescription forms are not sent out automatically and must be ordered from the supplier (De La Rue Smurfit) as and when required.

8. Allow at least 6 working days between notifying changes to the CSA and ordering prescriptions. This will allow time for data input and transmission of updated data files to De La Rue Smurfit. If you order too quickly after changing the details - the order may be rejected; any orders based on details which conflict with data held by De La Rue Smurfit will be rejected for security reasons.

9. Prescriptions are only sent to the registered address of the independent prescriber (eg GP surgery). Difficulties with prescription orders should be addressed, in the first instance, to De La Rue Smurfit. On receipt the prescriber should check that the details on the prescription forms is correct and that the correct quantity of forms have been received.

10. On receipt of prescriptions the first and last serial numbers of the batches need to be recorded in accordance with the prescription security guidance.

Prescription forms for independent prescribers.

11. The nurse or pharmacist will be identified by individual prescriber codes.

12. Currently any nurse or pharmacist who works for more than one employer or in more than one setting must have a separate prescriber code for each organisation/scenario, with the correct organisation in the identification details area of the prescription form.

13. Community trust employed nurse or pharmacist prescribers working across different GP practices must have a separate prescription pad for each practice at present. These arrangements may be reviewed in the future.

PRESCRIBING BY HOSPITAL-BASED NURSE AND PHARMACIST INDEPENDENT PRESCRIBERS

14. Nurse and Pharmacist Independent Prescribers prescribing for hospital inpatients use the relevant hospital prescription form or sheet. There is currently no requirement to notify the CSA of details of hospital based nurse or pharmacist prescribers.

NON-NHS EMPLOYEES

15. A non-HPSS Nurse or Pharmacist Independent Prescriber cannot issue an prescription to be dispensed in a community pharmacy, unless the organisation they work for has an arrangement /contract with an HPSS provider.

HOW TO COMPLETE THE PRESCRIPTION FORM

16. Detailed advice on prescription writing is contained in the British National Formulary (BNF) and the Nurse Prescribers' Formulary.

17. Details required on the front of the prescription form (to be entered by writing clearly and legibly using an indelible pen - preferably black or, where possible, by printing using a computer prescribing system) are as follows:

- The patient's title, forename, surname and address (including postcode and if available the patient's CHI number).
- Age and date of birth (must be printed by computer prescribing systems; for hand written prescriptions - enter if known e.g. from patient notes - it is a legal requirement to write the patient's age on the prescription when prescribing Prescription Only Medicines for a child under twelve years of age).
- For prescribing in primary care and in the community, 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)2 3 and special containers4 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 or litres), for topical preparations by mass (grams, g) or volume (millilitres, mL or ml). Terms such as "1 Pack" or "1 OP" should not be used. Alternatively, for preparations to be given at a fixed dose and interval, the duration(s) of treatment can be given in place of quantity to be dispensed
- 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 are being discharged.

- The names of medicines should be written clearly and nurses and pharmacists are recommended to prescribe generically at all times except in situations where this would not be clinically appropriate, for example, when prescribing sustained release preparations, anti-epileptic drugs, combination products and dressings. Exceptions to this rule are for the prescribing of some dressings and appliances, and of compound or modified release medicines which have no approved non-proprietary name. Names of medicines and generic titles should not be abbreviated.
  directions, should be written 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).

2 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.
3 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.
4 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.

- Prescriber's signature and date.
- On hospital prescriptions only: the Nurse or Pharmacist Independent Prescriber's name printed or hand written in the box provided - to ensure that the dispensing pharmacist is aware who to contact if s/he has a query.

Security and safe handling of prescription forms: good practice

18. The security of prescription forms is the responsibility of both the employing organisation and the 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 to keep prescription forms up-to-date - they are normally revised annually.

19. The prescriber's employer should record the serial numbers of prescriptions received and subsequently issued to an individual prescriber, surgeries, clinics etc.

20. Local policy should be established on monitoring the use of prescription forms to deter the creation of fraudulent prescriptions.

21. The prescriber should also keep a record of the serial numbers of prescriptions issued to him or her. 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.

22. Blank prescription forms must **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 a desk, but rather placed in a locked drawer.

23. 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.

Loss of prescription forms

24. De La Rue Smurfit should be contacted about prescriptions ordered, but not received. The CSA should only be notified if missing items are not found.

25. All prescribers working in primary care should report any confirmed loss or theft of prescription forms as soon as possible to:

- Their employer;
- the CSA (telephone 028 90 535650) and
- the drug squad (telephone 028 90 650222).

The prescriber should give details of the approximate number of prescriptions stolen, their identification numbers, and where and when they were stolen.

26. CSA should notify local pharmacists and decide upon any necessary action to minimise the abuse of the forms.

27. Following the reported loss of a prescription form, the CSA will inform by memorandum all pharmacies in Northern Ireland of the name and address of the prescriber concerned; the approximate number of prescription forms stolen This will normally be put in writing within 24 hours - with the exception of weekends.

28. It is the responsibility of the employer to ensure that:

- prescription pads are retrieved from prescribers who leave their employment for whatever reason. NB Prescription pads should be securely destroyed, e.g. by shredding and putting into 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 prescribers have left employment would still be charged to the appropriate budget.
- no further prescription pads are ordered for a prescriber who has left his/her employment or who has been suspended from prescribing duties, and all unused prescription forms are recovered, recorded and securely destroyed relating to that prescriber.

NB All of the above requirements highlight the need for clear channels of communication,

Prescribing Information and Advice for nurse and pharmacist Independent/Supplementary Prescribers

29. The CSA purchases regular supplies of the British National Formulary and the British National Formulary for Children. Access to these resources is also available via the National Electronic Library for Health and the internet. Not all prescribing professionals may need their own hard copy and many may find electronic access more convenient, especially as NHS IT systems develop further.
Nurse and pharmacist Independent Prescribers will receive a centrally funded BNF six monthly.

30. The NI **Drug Tariff is available electronically to all prescribers** via the CSA website www.centralservicesagency.com

Annex E - Product Licence Definitions

Licenced medicines are medicines with a UK marketing authorisation. When prescribed within the terms of the marketing authorisation the manufacturer is likely to be found liable for any harm caused by the medicine.

Marketing authorisation define the clinical indications for which a licenced medicinal product can be marketed and also defines the form, dose, route of administration and the patient age group which the medicine can be used in and the container in which the product is supplied. A pharmaceutical company cannot promote an unlicenced medicine or a licenced medicine for an unlicenced indication.

Off label medicines are medicines with a UK marketing authorisation, which are prescribed for an unlicenced indication or via a different route etc (i.e. outwith the terms of the marketing authorisation). If a patient is harmed by such use of a medicine then the manufacturer is unlikely to be found liable,unless harm is directly attributable to a defect in the medicine, rather than the way in which it was prescribed.

Examples: -sodium valproate as a mood stabiliser.
-use of numerous medicines, licenced for use in adults, but used in the treatment of children.

Unlicenced medicines are medicines without a UK marketing authorisation and include:

- medicines prepared by a UK manufacturer but not for sale in the UK and may include medicines undergoing clinical trial, medicines awaiting a UK marketing authorisation, medicines withdrawn from the UK market, or medicines manufactured for export. Such medicines are usually available on an individual patient basis.
  Examples, primidone tablets, pyrazinamide tablets.
- medicines prepared outside the UK with a marketing authorisation from the country of origin. Such as medicines imported into the UK.
  Examples, vitamin A drops from Italy.
- 'Specials' obtained from a hospital or commercial supplier with a manufacturer's 'specials' licence. Such medicines can be supplied against an unsolicitated order or prescription.
  Example, captopril suspension.

- extemporaneously dispensed medicines prepared for a specific patient under the supervision of a pharmacist in accordance with a practitioner's prescription, including TPN compounding, IV additive and cytotoxic reconstitutions.
  Example, azathioprine suspension.
- re-packed medicines. These are medicines which are removed from their original containers and re-packed during dispensing or ward stock 'packdown' procedures.
  Example, flucloxacillin capsules 250mg for a 5 day treatment course packed down from a larger manufacturer's pack.
- Chemicals used to teat rare metabolic disorders.
  Example, L-arginine powder for urea cycle disorder.

Some of the above examples are common practice (e.g. repackaged medicines) and raise little concern for prescribers or patients, whereas others, though sometimes accompanied by published evidence of efficacy, raise concerns over unfamiliarity with prescribing, quality assurance and liability.

Annex F - Web Links for Further Information

❍ The Department of Health Social Services and Public Services
www.dhsspsni.gov.uk

❍ Central Service Agency
www.centralservicesagency.com

❍ The Department of Health
www.dh.gov.uk

❍ The National Prescribing Centre
www.npc.co.uk

❍ The Medicines and Healthcare products Regulatory Agency
www.mhra.gov.uk

❍ The National Patient Safety Agency
www.npsa.nhs.uk

❍ The Nursing and Midwifery Council
www.nmc-uk.org

❍ The Pharmaceutical Society of Northern Ireland
www.dotpharmacy.com/psni

❍ The Royal Pharmaceutical Society of Great Britain
www.rpsgb.org.uk

❍ The NMC's Standards of proficiency for nurse and midwife prescribers
www.nmc-uk.org

❍ The Northern Ireland Practice and Education Council
www.nipec.n-i.nhs.uk

❍ 'Maintaining competency in prescribing - outline frameworks to help nurse prescribers and pharmacist prescribers'
http://www.npc.co.uk/non_medical/competency_frameworks.htm

❍ Northern Ireland Centre for Pharmacy Post Graduate Education and Training NICPPET
www.nicppet.co.uk

❍ Queens University Belfast
www.qub.ac.uk

❍ Universty of Ulster
www.ulster.ac.uk

Appendix 1 - Examples of Good Practice for Non-Medical Prescribing Clinical Governance Frameworks

1. The Royal Pharmaceutical Society of Great Britain's document entitled 'Clinical governance framework for pharmacist prescribers and organisations commissioning or participating in pharmacist prescribing (GB wide)' is available at: http://www.rpsgb.org.uk

2. Trent Strategic Health Authority's 'Non-medical Prescribing Clinical Governance Framework' (see pages 44 - 47)

3. North and East Yorkshire and Northern Lincolnshire's 'Non-Medical Prescribing - An Outline Governance Framework for Local Organisations' (see pages 48 - 49)

Trent NHS

Strategic Health Authority

Non-medical Prescribing Clinical Governance Framework

Lorraine Wright
Education Development Manager- Advanced Practice
Trent Multi-Professional Deanery

Chris Orme
Head of Clinical Governance
Trent SHA

Patient Experience and involvement

The Trust should demonstrate:

- Patient information is available outlining Non-medical prescribing.
- Patient forums have been informed about the development of Nonmedical Prescribing.
- Mechanisms are being developed to support concordant consultations
- Increased patient choice and access to appropriate health professionals.

Use of information

The Trust should demonstrate:

For Non-medical prescribers that:

- Co-ordinated systems are in place to ensure all non-medical prescribers are kept informed of all the relevant clinical information, i.e. changes with immediate effect, Drug alerts. Hazard warnings
- Information is available to individuals regarding their prescribing practice (PACT data).
- Prescribers are aware of the importance of using the yellow card system to report Adverse Drug Reactions. (ADRs)
- Prescribers are aware of the importance of reporting untoward incidents to the PCT and to the NPSA.
- Information is disseminated on the Trust policy regarding involvement with the Representative of the Pharmaceutical Industry.

For the Trust

- A co-ordinated system/ database is kept listing all prescribers and their status

- Health Visitor/District Nurse HV/DN,
- Extended Formulary Nurse Prescriber/Nurse Supplementary Prescriber EFNP/NSP,
- Pharmacist Supplementary Prescriber, PSP,
- Extended Formulary Nurse Prescriber, EFNP
- Allied Health Professional Supplementary Prescriber
- Optometrist Supplementary Prescriber

- Systems are in place to inform Non-Medical Prescribing lead in the Trust when new prescribers are employed and prescribers leave.
- A system is in place for the ordering and safe distribution of prescription pads to prescribers.
- A system is in place to retrieve prescription pads when staff leave the organisation
- A contact point within the Trust for any queries on the prescribing status of staff. i.e. from dispensing pharmacists
- Structures for organisational use of PACT data to monitor prescribing trends.
- System for receipt of information from the Education Development Manager (Non-medical Prescribing) and the University about the status of Trusts applicants to the course and results.

Processes for Quality Improvement

The Trust should demonstrate:

- A Trust Non-medical Prescribing Policy exists and is available to all Nonmedical prescribers. The policy needs to include;
  - Writing prescriptions,
  - Record keeping,
  - Accountability and liability,
  - Security and safe handling of prescription pads
- The organisation has considered the impact of Non-medical Prescribing on other policies such as incident reporting, drug errors and near miss major incidents.
- Non-medical prescribing/CNST standards.
- Promotion of evidence based practice.
- Procedures are in place for ordering and distributing the latest available
  copy of the BNF/NPF to Non-medical prescribers

- Raise awareness of Non-medical prescribing within the organisation to Doctors, Nurses, Pharmacists and Managers by means of briefings, bulletins.
- Review the need for Trust Prescribing guidelines/protocols with regard to Clinical Management Plans for supplementary prescribing, i.e. Chronic Disease Management, Wound Care.
- Provide evidence of monitoring the implementation of Clinical Management Plan development.

- Assessment of the potential need for Non-medical prescribing within the Trust.
- Reduction of semi-legal or illegal practices involving prescribing medications, i.e. pre-signed prescriptions, issuing stock supplies.
- Evidence of how the organisation will address competency issues.
- Clinical Audit of Non-medical Prescribing.

Staff Management

The Trust should demonstrate:

- Effective infrastructures to develop, implement and monitor non-medical prescribing.
- Job descriptions are amended to account for prescribing responsibilities.
- An SLA or written agreement for staff employed or contracted to work in the Trust that they will follow Trust guidelines and Clinical Governance requirements.
- All non-medical prescribing staff receive an annual appraisal with reference to prescribing.
- Effective systems are in place to provide Continuous Professional Development - Multi-professional might be an option in the future.
- Ethical consideration of pharmacist prescribing and dispensing activity for Community Pharmacists.

Leadership Strategy and Planning

The Trust should demonstrate that:

- A Non-medical Prescribing lead in each Trust, regularly attends steering group meetings held in each locality with the Education Quality Manager (Non-medical Prescribing) from the Multi Professional Deanery.
- A clear organisational structure exists with the Trust Non-medical Prescribing lead reporting directly to the Professional Executive Committee and to the Board.
- Local Delivery Plans reflect the development of Non-medical prescribing.
- Consider Non-medical prescribing within service development in response to the GMS contract.
- An assessment of the suitability of those wishing to access the course takes place, i.e. are they working in a position that requires them to be a prescriber? Are they willing to prescribe once qualified?

Non-Medical Prescribing
An Outline Governance Framework for Local Organisations

Michele Cossey- Clinical Development Manager Pharmacy & Prescribing
NEYNL WDC

The development of non-medical prescribing (NMP) is a key policy initiative that aims to maximise benefits to patients and the NHS by:

- Providing better access to medicines and
- Better, more flexible use of the workforce skills

As NMP is rolled out nationally and locally it is important that all those involved understand the responsibilities of individual practitioners, managers and organisations in ensuring safe and effective implementation and practice of NMP.

Ensuring patient safety is an integral part of all healthcare providers' clinical governance arrangements5.
The Department of Health (DH) have set out key steps for NHS organisations to have in place to ensure the implementation of clinical governance6 7 8.

These include:

- Clear lines of responsibility and accountability for overall quality of clinical care
- Development of quality improvement programmes
- Management of risk
- Clear procedures to identify and remedy poor performance.

This NEYNL wide ***Non-medical Prescribing Governance Framework*** sets out the key elements that organisations and individual practitioners should have in place or be in the process of addressing, in order to ensure that the development of NMP is implemented within a mechanism that develops safe and effective practice.

The Framework should be read in conjunction with any policies and procedures that local organisations have in place for implementing NMP or any general policies related to prescribing and medicines management. It should also be read in conjunction with any national or professional guidance issued by regulatory bodies for any of the non-medical professions eligible to train as prescribers. (Nurses, Pharmacists, Optometrists, Allied Health Professionals (AHPs) - currently physiotherapists, podiatrists, and radiographers).

5 Building a safer NHS for patients: implementing an organisation with a memory. DoH 2001
6 Clinical Governance: Quality in the new NHS. HSC 1999/065
7 Clinical Governance Guidance WHC(99)54
8 Clinical Governance MEL(98)75

1.Organisational Leadership and strategy for Non-medical Prescribing (NMP)

Overarching statement: **Clear lines of responsibility and accountability exist for all organisations in relation to the leadership, planning and implementation of NMP**	
Governance arrangements required by organisations:	a) All organisations have a nominated named lead (or leads) for overseeing the development and implementation of NMP. Where different professional leads are in place co-ordination / networking between these leads is required to ensure consistency of approach to implementation and monitoring. NMP should be linked into organisation prescribing and medicines management arrangements within the organisation where appropriate.
	b) Organisations should have in place an integrated policy around the strategic development and implementation of NMP. This should include: named leads for NMP, stakeholder and patient/public awareness initiatives, implementation plans for NMP, advice about training, internal arrangements for monitoring, mechanisms for application and training, processes for obtaining prescription pads, signposting to any relevant policies and procedures and any other relevant local information.

Overarching statement: **Clear lines of responsibility and accountability exist for all organisations in relation to the leadership, planning and implementation of NMP**	
	c) A co-ordinated database or register of all trained non-medical prescribers should be maintained within all organisations. (For PCTs this should cover PCT employed and independent contractor employed staff). This database record all newly qualified prescribers; those employed by the PCT/Trust and should note those NMPs who leave the organisation. It should also note the designated status of all NMPs (e.g. Community Practitioner Formulary, Extended Formulary, Supplementary Prescriber) and the profession of the prescriber i.e. nurse, pharmacist, physiotherapist, radiographer podiatrist or optometrist.
Governance arrangements required by organisations (cont):	d) Non-medical prescribing is an integrated part of organisational clinical governance arrangements and relevant Action Plans. Organisations must consider the impact of NMP on other related policies and procedures e.g. drug error reporting.
	e) All planned developments for NMP should be linked to strategic service development within the organisation For example: Long term conditions, improved access to medicines and services, practice based commissioning; service modernisation and redesign.
	f) Decisions to train individuals as NMPs should be linked to Personal Development Plans and candidates should be assessed for competency related to knowledge and skills in their area of potential prescribing practice. Competency Frameworks for NMPs are available from the National Prescribing Centre at www.npc.co.uk/ *(Note: it is not intended that individuals are competent to "prescribe" prior to training but organisations should be assured that practitioners have the necessary clinical skills and knowledge in their area of practice which will enable them to prescribe safely and effectively once trained **OR** that CPD and additional training is planned to ensure these can be met. Organisations should also check that individuals would meet the necessary Higher Educational Institute (HEI) entry requirements).

Overarching statement: **Clear lines of responsibility and accountability exist for all organisations in relation to the leadership, planning and implementation of NMP**	
	g) All plans to train NMPs should also include an assessment of: service specification, access to a prescribing budget (or equivalent in acute Trusts / secondary care), development of necessary policies or documentation e.g. Clinical Management Plans (CMP)
	h) Links should exist between NHS organisations, HEIs and commissioners of training (SHA/WDCs) to ensure effective monitoring of applications, funding, quality of training and monitoring of numbers and professions trained and attrition rates from modules.
	i) Ongoing support and network arrangements are in place for all NMPs including access to relevant CPD.

2. Information governance and risk management of NMP

Overarching statement: Clear policies exist or links to existing polices are explicit for all manager and NMPs in relation to information governance and risk management of NMP.	
Governance arrangements required by organisations: (See also 1c above)	a) All NMPs should be linked to all organisational or local systems to ensure presribers are kept informed of relevant clinical, therapeutic and prescribing information e.g. MHRA alerts, Adverse Drug Reaction reports etc.
	b) NMP practice is monitored through the same routes as medical prescribing (e.g. PACT data systems, audit and feedback in primary care, local mechanisms in acute Trusts) and that information is available to individual practitioners and managers where appropriate and in line with internal arrangements.
	c) All NMPs are aware of the importance and know how to report ADRs via the national Yellow Card system
	d) All NMPs understand the importance of reporting Serious Untoward Incidents (SUIs) and are aware of the local mechanisms for doing this as well as the NPSA systems of reporting.
	e) NMP should be aware and adhere to the PCT/Trust policy regarding relationships with the Pharmaceutical Industry
	f) All record keeping guidance and protocols/templates for prescribing practice are updated regularly as detailed within PCT/Trust policies e.g. CMPs should be revisited and amended where necessary at least annually
Governance arrangements required by organisations (cont):	g) All medical prescibers should be aware of NMPs within the organisation and when and how they may interact with patients to ensure consistency of record keeping and continuity of patient care.

Overarching statement: Clear policies exist or links to existing polices are explicit for all manager and NMPs in relation to information governance and risk management of NMP.	
	h) Organisations should keep records of prescription pad numbers linked to prescriber name for tracking any lost or stolen prescriptions, where prescription pads are used (Acute Trusts use prescription charts). This includes for any OOH services or Walk-in-Centres. (GP practices should do this for practice nurses as they order them directly). i) Organisations should review their policies related to medico-legal accountability and information made clear to NMPs regarding accountability, vicarious liability and personal indemnity. (Practitioners should also be advised to contact their professional regulatory bodies). j) Organisations should have systems in place for identifying poor professional performance (as for other prescribers) and prescribing should be considered as part of this process and effective action taken.

3. Audit and Quality Improvement

Overarching statement: Mechanisms should be in place to include NMP in relevant audit. Audit cycles and review processes should be employed to ensure that the implementation and development of NMP is progressing in a safe and effective manner that is benefiting patients and services.	
Governance arrangements required by organisations:	a) All review and updating of PCT/Trust prescribing and medicines supply polices include an impact assessment of NMP and are revised accordingly.
	b) All CMPs used by Supplementary Prescribers are reviewed (at least annually but more frequently where changes to policy or evidence dictate) to ensure they are based on sound clinical evidence and are safe and cost effective.

Overarching statement: Mechanisms should be in place to include NMP in relevant audit. Audit cycles and review processes should be employed to ensure that the implementation and development of NMP is progressing in a safe and effective manner that is benefiting patients and services.	
	c) All NMP practice should be integral part of prescribing policy audit including adherence to NICE Guidance, National Clinical Guidelines and any relevant local or national prescribing and medicines management policies.
	d) Evidence of tracking and monitoring arrangements should be in place to ensure the continuing competency of NMPs and their access to relevant, appropriate CPD.

4. Patient and Public Involvement

Overarching statement: There should be mechanisms in place in organisations to ensure patients and public are aware of NMP practice and have a say in any related developments or audit of NMP services.	
Governance arrangements required by organisations:	a) Patients and the public should be made aware of any developments in NMP which may alter services in order that they can make informed choices and understand what NMP means for them and the delivery of their care. E.g. nurses / pharmacists/ AHPs, providing prescriptions and prescribing in the community or GP Practices.
	b) Methods to include patient and public comments in any NMP service review should be standard practice within all PCTs/Trusts
	c) Patient / Public information should be available in all PCTs/Trusts outlining what NMP is, what it means for patients and any specific services where NMP is being used in that area.
	d) Patient Public Involvement forums should be briefed about NMP where relevant and appropriate and information provided in a useable format.

5. Responsibilities of Individual NMP Practitioners

Whilst is understood that organisations need to have robust governance arrangements in place for their NMP staff, individual practitioners have responsibility for ensuring they are clinically competent for their role, undertake appropriate CPD, practice within the law and any agreed local policies and abide by their relevant professional regulatory body's Code of practice or ethics.

Guidance for prescribing practice and relevant standards are outlined by the NMC (for nurses) and the RPSGB (for pharmacists) and can be accessed via the following web addresses below.

http://www.nmc-uk.org

http://www.rpsgb.org/pdfs/clincgovframeworkpharm.pdf

The National Prescribing centre (NPC) has published competency frameworks for NMPs, which should be used by organisations, managers and individuals) to assess competence to prescribe. They also publish useful information for NMPs and regular therapeutic updates. These documents and other information can be accessed via the web link below.

http://www.npc.co.uk/non_medical.htm

The Department of health (DH) has also published guidance on implementing NMP for organisations as well as Frequently Asked Questions (FAQs) related to specific enquiries and this information can be found via the web link below:

http://www.dh.gov.uk/nonmedicalprescribing

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Department of Health, Social Services and Public Safety, Castle Buildings, Belfast BT4 3SQ
Telephone: (028) 9052 3236 Textphone: (028) 9052 7668
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