SUPPLEMENTARY PRESCRIBING BY NURSES AND PHARMACISTS WITHIN THE HPSS IN NORTHERN IRELAND

A guide for implementation

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

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HOW TO USE THE GUIDE

This guide has been prepared for:

- HPSS Trusts - Hospital and Community
- Area Health and Social Services Boards
- General Practitioners
- Community Pharmacists
- Local Health and Social Care Groups (LHSCGs)
- Higher Educational Institutions providing nurse education
- School of Pharmacy QUB
- School of Nursing QUB
- University of Ulster
- Northern Ireland Centre for Post-graduate Pharmaceutical Education and Training (NICPPET)
- Northern Ireland Practice and Education Council for Nursing & Midwifery (NIPEC)

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 supplementary prescribing. This guide has been prepared to assist them. Copies of all or part of the Guide may be reproduced at local level as required.

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

CONTENTS

Introduction

1. This guide sets out the administrative and procedural steps needed to enable registered nurses, health visitors (HVs) registered midwives and registered pharmacists to act as supplementary prescribers. It also provides advice on good practice for supplementary prescribers and their independent prescriber partner (doctor or dentist). The guide applies to both nurses and pharmacists. **[NB Where the term "nurse" is used in this document it includes Registered Midwives & Health Visitors]**

Scope of this guidance and effect of devolution

2. This guide sets out the steps required to implement supplementary prescribing in Northern Ireland. Medicines legislation permits the introduction of supplementary prescribing across the UK and this guide refers specifically to how it will be implemented in Northern Ireland.

Background

General

3. Supplementary prescribing has its basis in the recommendations of the final report of the Review of Prescribing, Supply and Administration of Medicines (1999), which recommended that two types of prescriber should be recognised:

- the independent prescriber who would be responsible for the assessment of patients with undiagnosed conditions and for decisions about the clinical management required, including prescribing.

- the dependent prescriber who would be responsible for the continuing care of patients who have been clinically assessed by an independent prescriber. This continuing care might include prescribing, which would usually be informed by clinical guidelines and be consistent with individual treatment plans, or continuing established treatments by issuing repeat prescriptions, with the authority to; add or delete drugs and adjust the dose or dosage form according to the patient's needs. The Review recommended that there should be provision for regular clinical review by the assessing clinician.

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

4. The Minister of Health and Social Services and Public Safety (DHSSPS) for Northern Ireland has decided that there would be benefit to the Health and Personal Social Services (HPSS) and to patients from the introduction of supplementary prescribing by nurses and pharmacists, following diagnosis by a doctor.

5. This decision followed formal consultation between April and July 2002. The results of the consultation were considered at meetings of the Committee on Safety of Medicines and the Medicines Commission in September 2002.

What is supplementary prescribing?

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

Legal basis of supplementary prescribing

7. The Medicines Act 1968 as amended by Section 63 of the Health and Social Care Act 2001 extended the prescribing responsibilities of doctors and dentists to include other health professions. In Northern Ireland the extension of supplementary prescribing rights to pharmacists was achieved through Article 47 of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003. These pieces of legislation has enabled the introduction of new types of prescribers, including the concept of supplementary prescribing, under certain conditions set out in the Prescription Only Medicines (Human Use) Order 1997, as amended by the Prescription Only Medicines Order 2003.

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

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

Aims of supplementary prescribing

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

Comparison with independent nurse prescribing and with Patient Group Directions

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

10. "Extended Formulary" independent nurse prescribers undertake a longer, specific programme of preparation and can prescribe from the Nurse Prescribers' Extended Formulary. This includes all Pharmacy and General Sales List medicines prescribable by GPs on the HPSS, together with a list of around 140 specified Prescription Only Medicines to treat conditions in four broad therapeutic areas - minor illness, minor injury, health promotion and palliative care.

11. Patient Group Directions are written instructions for the supply or administration of medicines to groups of patients *who may not be individually identified before presentation for treatment.* The DHSSPS has always made it clear that the majority of clinical care should be provided on an individual, patient-specific basis. Consequently the supply and administration of medicines under Patient Group Directions should be reserved for those situations where this offers an advantage for patient care (without compromising patient safety), and where it is consistent with appropriate professional relationships and accountability. Further detail is set in DHSSPS Guidance "Patient Group Directions" issued on 7th September 2000.

12. Supplementary prescribers prescribe in partnership with a doctor or dentist (the independent prescriber). They are able to prescribe all medicines (with the current exceptions of Controlled Drugs, unlicensed drugs unless they are part of a clinical trial which has a clinical trial certificate or exemption, and any restrictions set by Schedules 10 and 11 of the HPSS (General Medical Services) Regulations and products used outside their licensed indications ("off-label" use). They may prescribe for the full range of medical conditions, provided that they do so under the terms of a patient-specific Clinical Management Plan (CMP). The Plan will be drawn up, with the patient's agreement, following diagnosis of the patient by the independent prescriber, and following consultation and agreement between the independent and supplementary prescribers.

How supplementary prescribing will work

General principles

13. The independent prescriber **must** be a doctor or dentist. It is for the independent prescriber to determine which patients may benefit from supplementary prescribing and the medicines that may be prescribed by the supplementary prescriber under the CMP. S/he will clearly need to take account of the professional relationship between the independent and supplementary prescriber as well as the experience and areas and degree of expertise of the supplementary prescriber when coming to a decision.

14. Supplementary prescribing is a partnership between the independent and the supplementary prescriber, who between them should draw up and agree an individual CMP for the patient's condition before supplementary prescribing begins. Two sample draft templates, are given as Annexes C and D to this Guide. The templates have been produced to help in development of CMPs. The use of these templates is not mandatory. They can also be adapted/amended to suit local needs, or in some cases, it may be appropriate to develop CMPs from scratch. But there **must** be an individual CMP. Detailed information on what should be included in the CMP is set out in paragraph 48.

15. In each case the independent and/or supplementary prescriber should obtain the patient's agreement to supplementary prescribing taking place and then discuss and agree the CMP for that particular patient. The independent and supplementary prescribers must maintain communication while the supplementary prescriber is reviewing and prescribing for the patient. Ideally they should jointly carry out the formal clinical review at the agreed time - normally within a maximum of 12 months of the start of the CMP. (Periods longer than 12 months between joint clinical reviews or

reviews by the independent prescriber may occasionally be acceptable in the CMP where the patient's condition has been shown to be stable and deterioration of the condition is not to be expected during a longer period than 12 months. The appropriateness of such a longer period between joint or independent prescriber clinical reviews is the responsibility of the independent prescriber though it must be agreed with the supplementary prescriber). If a joint clinical review is not possible, the outcome of the clinical review by the independent prescriber needs to be discussed with the supplementary prescriber, who must agree continuation of, or changes to, the CMP.

16. The independent prescriber should be the clinician responsible for the individual's care at the time that supplementary prescribing is to start. If this responsibility moves from one independent prescriber to another (for example from the patient's GP to a hospital consultant, or from one GP to another), the supplementary prescriber may **not** continue to prescribe, unless he \ she negotiates and records in the patient record a new agreement to enter a prescribing partnership with the new independent prescriber. Supplementary prescribing partnerships involving more than one independent prescriber (eg shared care arrangements) are referred to in paragraph 22 below.

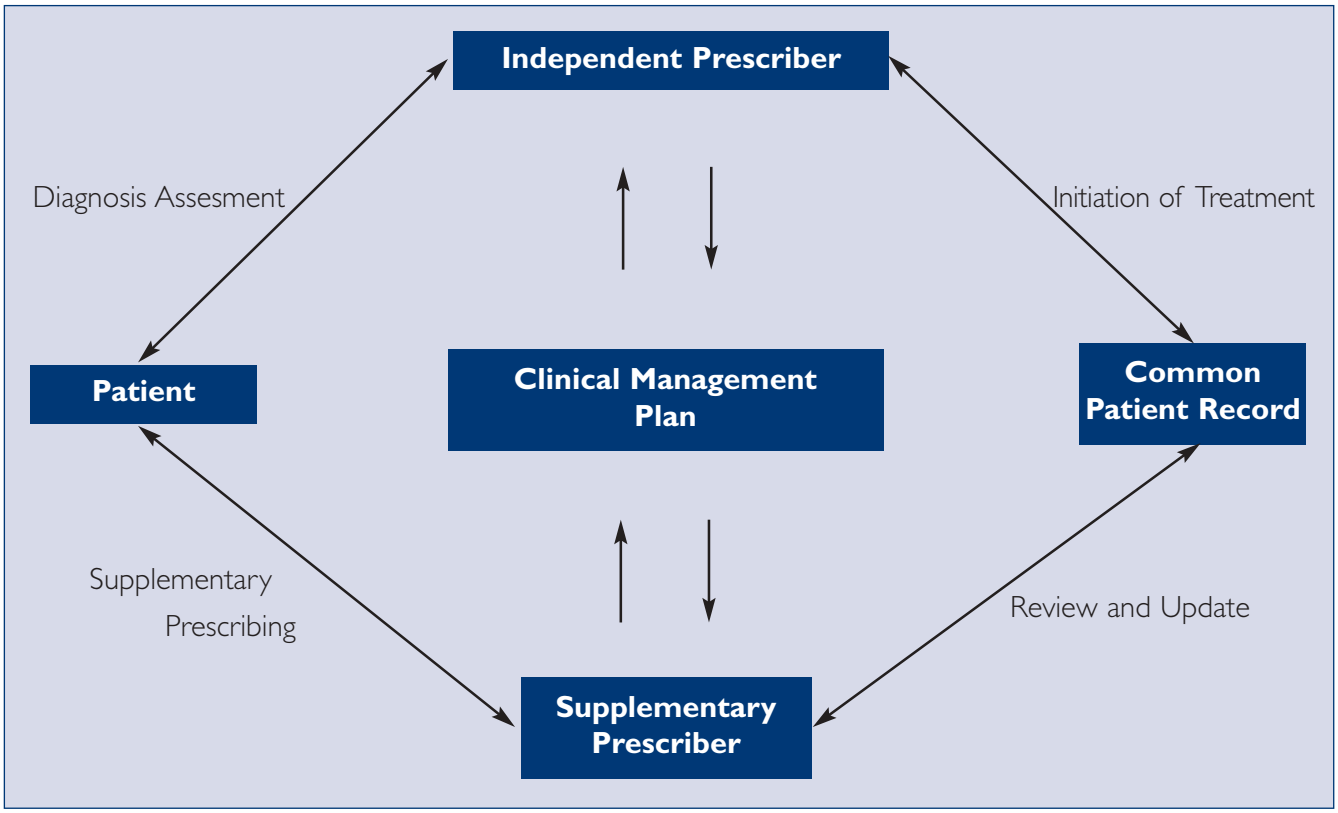

Figure 1 Schematic of the Supplementary Prescribing Process

Characteristics of Supplementary Prescribing

17. The key characteristics of supplementary prescribing are:

- Supplementary prescribing may only take place after a specified point in the individual patient episode, i.e. after assessment and diagnosis by an independent prescriber and the development of a written CMP agreed between the independent and supplementary prescriber.
- The independent prescriber is responsible for the diagnosis and setting the parameters of the CMP, although they need not personally draw it up.
- The supplementary prescriber has discretion in the choice of dosage, frequency, product and other variables in relation to medicines only within the limits specified by the CMP. The Plan may include reference to recognised and authoritative clinical guidelines and guidance (local or national), whether written or electronic, as an alternative to listing medicines individually. Any guidelines referred to should be readily accessible to the supplementary prescriber when managing the patient's care.
- Supplementary prescribing must be supported by a regular clinical review of the patient's progress by the assessing clinician (the independent prescriber), at pre-determined intervals appropriate to the patient's condition and the medicines to be prescribed. The intervals should normally be no longer than one year (and much less than this if antibiotics are to be included in the CMP). However as stated in paragraph 15 above, longer periods, during which the patient continues to be reviewed by the supplementary prescriber, may be appropriate when the patient's condition is stable and is expected to continue to be stable.
- The independent prescriber may, *at any time*, review the patient's treatment and/or resume full responsibility for the patient's care.
- The independent prescriber and the supplementary prescriber must share appropriate access to, consult, keep up to date and use the same common patient record to ensure patient safety.
- The CMP comes to an end :-
    - at any time at the discretion of the independent prescriber
    - at the request of the supplementary prescriber or the patient
    - at the time specified for the review of the patient (unless it is renewed by both prescribers at that time).

18. The key to safe and effective supplementary prescribing is the relationship between the individual independent prescriber and the individual supplementary prescriber. These two professionals should:

- Be able to communicate easily
- Share appropriate access to, consult relevant information, keep up-to-date and use the same common patient record to support the supplementary prescriber and ensure optimal care while respecting patient confidentiality.
- Share access to the same local or national guidelines or protocols, where these are referred to in the CMP
- Agree and share a common understanding of and access to the written CMP
- Ideally, jointly review the patient's progress at agreed intervals.

Responsibilities

19. The independent prescriber is responsible for:

- The initial clinical assessment of the patient, the formulation of the diagnosis and determining the scope of the CMP
- Reaching an agreement with the supplementary prescriber about the limits of their responsibility for prescribing and review - which should be set out in the CMP
- Providing advice and support to the supplementary prescriber as requested
- Carrying out a review of patient's progress at appropriate intervals, depending on the nature and stability of a patient's condition.
- Appropriate sharing of the common patient record with the supplementary prescriber.
- Reporting adverse incidents within local risk management or clinical governance schemes (this is separate from Adverse Reaction Reporting - see paragraph 64-65 below)

20. The supplementary prescriber is responsible for:

- Prescribing for the patient in accordance with the CMP. Altering the medicines prescribed, within the limits set out in the CMP, if monitoring of the patient's progress indicates that this is clinically appropriate

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

Working together

21. Independent and supplementary prescribers must be willing and able to work together and to assume the specific responsibilities listed above.

22. Independent and supplementary prescribers may work in more than one prescribing partnership, providing that in each case they work as described above.

The process

23. Before starting to undertake supplementary prescribing, the supplementary prescriber will need to:
    - Successfully complete the specified training and preparation for supplementary prescribing, including all assessments and the period of learning in practice
    - Ensure that their supplementary prescribing competency is recorded on the relevant professional register (Nursing and Midwifery Council or Pharmaceutical Society of Northern Ireland)
    - Agree with the independent prescriber to enter into a prescribing partnership with them, and record that agreement in the patient's record
    - Agree the CMP for a patient with the independent prescriber
    - Make arrangements with their employer and /or the independent prescriber for access to prescription pads or other mechanisms for prescribing which are appropriate to the setting, for example patients' drug charts in hospitals

- Arrange for access to an identified budget to meet the costs of their prescriptions
- Reach agreement with their employer that supplementary prescribing should form part of their professional responsibilities.

Conditions and health needs that can be included

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

Patient consent

25. Wherever it is proposed to manage a patient's condition through the use of supplementary prescribing, the principle underlying the concept of supplementary prescribing (i.e. a prescribing partnership) **must** be explained in advance to the patient by the independent or supplementary prescriber and their agreement should be obtained.

26. The agreement of the patient to the prescribing partnership should be recorded in the CMP and patient record. Without such agreement, supplementary prescribing may not proceed. Following implementation this issue will be reviewed to consider those patients not competent to give consent and who may be denied a supplementary prescribing service yet might benefit from the same.

Who can undertake supplementary prescribing?

Which nurses and pharmacists can be supplementary prescribers?

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

28. A supplementary prescriber who is a pharmacist must be a registered pharmacist whose name is held on the membership register of the Pharmaceutical Society of N. Ireland, with an annotation signifying that the pharmacist has successfully completed an approved programme of training for supplementary prescribing.

Selection of nurses and pharmacists to be trained

29. The selection of nurses and pharmacists who will receive training in prescribing is a matter for local decision, in the light of potential benefits for patients and local HPSS needs. No nurse or pharmacist shall be required to undertake training unless he/she wishes to do so. All individuals selected for prescribing training must have the opportunity to prescribe in the post they will occupy on completion of training.

30. In addition to fulfilling the legal criteria for eligibility to prescribe, applicants will also need to meet the following:

- At least three years post-registration clinical nursing experience or at least 2 years experience as a pharmacist following their pre-registration year after their graduation. Nurse nominees will be 1st level registered nurses with appropriate experience and on live Nursing & Midwifery Council (NMC) register.
- The support of their employer or HPSS Board to confirm that
  - their post is one in which they will have the need and opportunity to act as a supplementary prescriber;
  - 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.

31. 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
- better use of nurses' and pharmacists' skills.

Training and preparation for supplementary prescribing

32. Nurses, Midwives & Health Visitors preparing for supplementary nurse prescribing will undertake a specific programme of preparation for both extended independent & supplementary prescribing at degree level (level three) or postgraduate level (level M). The programme will be offered through a combination of e-learning, independent study and face to face interaction, which will include skills teaching, workshops, discussions and seminar presentations. Students will also complete the equivalent of 15 days supervised practice when a designated supervising medical practitioner will provide the student with supervision, support and opportunities to develop competence in prescribing practice.

The programme will be part time over a period of 1 year. The course carries 60 credits and this requires approximately 600 hrs of effort from the student or the equivalent of 75 days. Of this, 15 days are in practice and 10 days attendance at University. While students may be expected to use some of their own time for study, employers should be providing additional study time of 1 to 2 days a week.

The programme will include an assessment of theory and practice that must be passed before the student's entry on the (NMC) register can be annotated to indicate that they hold the prescribing qualification for supplementary nurse prescribing.

The standards for the preparation for supplementary nurse prescribing have been set out by the (NMC). They are in addition to, and do not replace, the standards for the preparation of District Nurse/Health Visitor prescribers, who will continue to qualify to prescribe through their specialist practitioner programmes.

The training programme includes health assessment, pharmacology, therapeutics, public health issues, practical aspects of prescribing and the safe and secure handling of medicines. It also includes the local and financial aspects of nurse prescribing.

Northern Ireland Practice and Education Council (NIPEC) will approve on behalf of (NMC) Higher Education Institutions which apply to provide the specific programme of preparation. Nurses can *only* qualify to prescribe by attending an approved nurse prescribers' programme of preparation.

Other training and education

Although many Universities, and some pharmaceutical companies, offer training and education in aspects of pharmacology and medicines management, *approved programmes of preparation for nurse prescribing will be recorded by the NMC.* However, the Higher Education Institutions offering the specific programme of preparation for the Extended Formulary may accredit the nurse prescriber's prior learning.

33. Pharmacists training to be supplementary prescribers will undertake a specific programme of training. This programme will comprise around 25 taught days by a recognised educational provider, which could be a school of pharmacy, plus at least 12 days 'learning in practice' (see para 32).

34. It will be for HPSS Boards and HPSS Trusts in collaboration with independent contractors to determine which nurses and pharmacists to put forward for the programme of training and preparation.

35. In November 2002, the Nursing and Midwifery Council (NMC) agreed a set of standards for the preparation of nurse prescribers. A copy of these is attached at Annex A. The NMC is responsible for quality assuring the specific programmes that Higher Education Institutions put forward for approval. Although some Universities and pharmaceutical companies already offer training and education in aspects of pharmacology and medicines management, only NMC approved programmes of preparation for nurse prescribing will be accepted by them when recording a nurse's qualification. Higher Education Institutions offering the specific programme of preparation may accredit the nurse's prior learning.

36. The Pharmaceutical Society of Northern Ireland (PSNI) has endorsed a curriculum for pharmacists to become supplementary prescribers (Annex B). PSNI will be responsible for accrediting courses for pharmacists provided by recognised providers. Pharmacists will normally be expected to complete the full training programme. However, providers offering an agreed programme of training may accredit the pharmacist's prior learning in prescribing. All candidates must complete all assessments, including satisfactory completion of the period of learning in practice

37. The programme for nursing will be part-time over a period of one academic year. 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.

38. Once the nurse or midwife has successfully completed the prescriber preparation, the NMC will be notified. The individual's entry on the NMC professional register will be annotated to indicate that she/he has qualified as a nurse prescriber for the Extended Formulary. A nurse, health visitor or midwife cannot legally prescribe until this annotation has been made. (This will be a different annotation to that used for district nurses and health visitors who completed preparation to prescribe from the current NPF). The NMC 24-hour Voice Bank telephone line[1] will confirm to an enquirer whether or not a nurse is eligible to prescribe, and whether from the formulary for district nurses and health visitors or from the Extended Formulary or as a Supplementary Prescriber. The Higher Education Institution will advise the individual's employer of successful/unsuccessful completion of the prescribing programme. For nurses successfully completing the programme, the employer is then advised to take action.
(Refer to Annex E)

39. Pharmacists will also be required to pass all components of the assessment, prior to the Pharmaceutical register being annotated to indicate that they have successfully completed the programme and have qualified as supplementary prescribers.

40. Central funding is being made available to meet the direct costs of training.

Preparation for independent prescribers

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

Continuing Professional Development (CPD)

42. All nurses and pharmacists have a professional responsibility to keep themselves abreast of clinical and professional developments. Supplementary prescribers will be expected to keep up-to-date with best practice in the management of conditions for which they may prescribe, and in the use

[1] Telephone number 020 7631 3200

of the drugs, dressings and appliances. Nurses may use the learning from this activity as part of their Post Registration Education and Practice (PREP-CPD) activity. For pharmacists it will contribute to the PSNI's CPD requirements. The curriculum for pharmacists states that pharmacists who register as supplementary prescribers will need to demonstrate evidence of relevant CPD to ensure that their prescribing skills are kept up-to-date and are extended as their prescribing role develops. The employer should ensure that the practitioner has access to relevant education and training provision. The Northern Ireland Centre for Post-Graduate Education and Training (NICPPET) offers programmes that may be relevant for pharmacist supplementary prescribers (see website www. nicppet.org.uk)

Evaluation Audit and Clinical Governance of Supplementary Prescribing

43. Supplementary prescribing needs to take place within a framework of clinical governance. Clinical supervision sessions for nurses provide an excellent opportunity for reflection on prescribing, as well as other aspects of practice. The model of clinical supervision should be agreed at local level, taking account of other staff support mechanisms and resources. It should be monitored and evaluated regularly.

44. Peer review, support and mentoring arrangements should be established for pharmacists. Audits and clinical governance arrangements will allow pharmacists to reflect on their prescribing practice. The PSNI will develop clinical governance guidance for pharmacist supplementary prescribers, which can be reflected in the employer organisation's overall clinical governance framework.

45 A general review of supplementary prescribing arrangements should be carried out as part of the overall prescribing monitoring arrangements.

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

47. Other assistance with identifying audit methodologies and interpreting findings should be available through the employing organisations' normal clinical governance mechanisms.

The Clinical Management Plan (CMP)

48. The Clinical Management Plan is the foundation stone of supplementary prescribing. *Before* supplementary prescribing can take place, it is *essential* that there is an agreed CMP in place (written or electronic) relating to a named patient and to that patient's specific condition(s) to be managed by the supplementary prescriber. This should be included in the patient record. Amendments to the Prescription Only Medicines (Human Use) Order 1997 specify that the CMP must include the following:

- A reference to the medicines (by individual medicine or class of medicines) that may be prescribed for the named patient by the supplementary prescriber. The CMP may include a reference to published national or local guidelines. However these must **clearly** identify the range of the relevant medicinal products to be used in the treatment of the patient, and the CMP should draw attention to the relevant part of the guideline. The guidelines also need to be easily accessible.
- the circumstances within which the supplementary prescriber can vary the dosage, frequency and formulation of the specified medicines. As indicated above reference may be made to published local or national guidelines.
- the circumstances in which the supplementary prescriber should refer back to the independent prescriber
- relevant warnings about any known sensitivities of the patient to particular medicines and arrangements for the notification of any adverse reactions (see also paragraphs 64 and 65).
- the date on which the supplementary prescribing arrangements commence and the date by which the arrangements should be reviewed.
- The formal agreement to the Clinical Management Plan of the independent and supplementary prescribers, and of the patient.

49. The CMP should be kept as simple as possible. It may refer to national or local evidence-based guidelines to identify the medicines that are to be prescribed, or circumstances in which dosage, frequency or formulation should be changed. There is no need to repeat the advice in these guidelines in the body of the CMP itself, nor need the CMP repeat detailed patient information that is contained in the patient's record shared by both prescribers, unless such information is essential for clarity and patient safety.

50. Following diagnosis by the independent prescriber, the independent and supplementary prescriber will probably need to discuss the CMP before the document itself is prepared. Either the independent or supplementary prescriber may draft the CMP; however, both must formally agree to the CMP before supplementary prescribing can begin.

51. The independent prescriber and supplementary prescriber must share appropriate therapeutic access to, consult and use the same common patient record. Shared electronic records are ideal, but existing paper records or patient-held records can also be used. The CMP may need to contain different levels of detail, if the independent and supplementary prescriber work in different locations (e.g. a hospital-based independent prescriber and an outreach supplementary prescriber in the patient's home). Potential templates for CMPs can be found at Annexes C and D to this document.

52. It is for the independent prescriber to determine the extent of the responsibility he or she wishes to give to the supplementary prescriber under the CMP. The independent prescriber will clearly need to take account of the experience and areas of expertise of the supplementary prescriber, and the professional relationship between the independent and supplementary prescriber(s), when coming to this decision.

Medicines prescribable under supplementary prescribing arrangements

53. The CMP may include any General Sales List, Pharmacy, or Prescription Only Medicine prescribable at HPSS expense, with the current exception of Controlled Drugs (but see also paragraph 12 above).
This includes the prescribing of:

- Antimicrobials
- "Black triangle" drugs and those products suggested by the British National Formulary to be "less suitable" for prescribing as denoted by the symbol in the BNF

- Products used outside their licensed indications (ie "off-label" use), provided that the product is licensed for use in the UK. Such use must have the joint agreement of both prescribers and the status of the drug should be recorded in the CMP.

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

a) a clinical trial is being undertaken under a clinical trials certificate or an exemption, and

b) their use has the joint agreement of both prescribers and the status of the drug is recorded in the CMP.

54. The independent prescriber will need to be aware of the high risk nature of many drugs prescribed under local shared care guidelines (e.g. methotrexate) and the specific monitoring requirements to support the safe and efficacious use of these drugs. Before undertaking a supplementary prescribing arrangement involving any high risk drug, the independent prescriber will need to assure him/herself that the supplementary prescriber has the level of skill/knowledge to take part in such an arrangement. It is also recommended that where appropriate/relevant, independent and supplementary prescribers take cognisance of guidance issued by the Regional Specialist Drugs Group.

55. A supplementary prescriber should not agree to prescribe any medicine if s/he feels that his/her knowledge of the medicines s/he may be asked to prescribe falls outside his/her area of competence.

The Patient Review

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

Good practice, ethics and issues common to all supplementary prescribers

Stock items

57. In primary care settings, supplementary prescribers should not write stock orders under the supplementary prescribing scheme.

Informing patients

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

Prescribing for self, family and friends

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

Patient Records

60. All nurses are required to keep contemporaneous records, which are unambiguous and legible. The NMC Standards for Records and Record Keeping outline the requirements of a nurse's records. The prescription details, together with other details of the consultation with the patient, should be entered into the record shared with the independent prescriber as soon as possible and preferably contemporaneously. It should be marked to indicate that it is the prescription of a supplementary prescriber, and should include the name of the supplementary prescriber. The maximum time to be allowed between writing the prescription and entering the details into the general record is for local negotiation, but best practice suggests that this should be immediately. Only in exceptional circumstances (e.g. the intervention of a weekend or public holiday) should this period exceed 48 hours from writing the prescription. Arrangements for the sharing of patient records should be put into place at the same time as the supplementary prescribing partnership is

set up. The record of the nurse's or midwife's prescription should also be entered into the nursing patient record (where a separate nursing record exists) at the time of writing.

61. Pharmacists must record all details. This information should ideally be entered in the common patient record immediately and pharmacists should not have a system of separate records. If, however, this is not possible, a separate record should be made which should be transferred to the same common patient record as soon as possible. Only in exceptional circumstances (e.g. the intervention of a weekend or public holiday) should this period exceed 48 hours from writing the prescription.

62. It is recommended that the record clearly indicates the date, the name of the prescriber, the name of the item prescribed and the quantity prescribed (or dose, frequency and treatment duration). For medicinal preparations, items to be ingested or inserted into the body, it is recommended that the name of the prescribed item, the strength (if any) of the preparation, the dosing schedule and route of administration is given e.g. "paracetamol oral suspension 120mg/5mls, 5mls to be taken 4 hourly by mouth as required for pain, maximum of 20mls in 24 hours". For topical medicinal preparations, the name of the prescribed item, the strength (if any), the quantity to be applied and frequency of application should be indicated. For dressings and appliances, details of how to be applied and how frequently changed are useful. It is recommended that the advice given on General Sales List (also known as "Over The Counter") items is recorded, although this is not mandatory.

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

Adverse Reaction Reporting

64. If a patient suffers a suspected adverse reaction to a prescribed, over-the-counter (General Sales List) or herbal medicine, the adverse reaction should be reported via the Yellow Card Scheme. The Yellow Card Scheme is a voluntary scheme through which healthcare professionals (including nurses and midwives) notify the Medicines and Healthcare products Regulatory Authority (MHRA)/Committee on the Safety of Medicines (CSM) of suspected adverse drug reactions. The MHRA/CSM encourage the reporting of all suspected adverse drug reactions to newly licensed medicines that are under intensive monitoring (identified by a "black triangle" symbol both on the

product information for the drug and in the BNF and MIMS) and all serious suspected adverse drug reactions to all other established drugs. Serious reactions include those that are fatal, life threatening, disabling, incapacitating or which result in or prolong hospitalisation and/or are medically significant. The new electronic Yellow Card provides a simple and fast way to report suspected adverse reactions. The electronic Yellow Card, together with instructions on how to use it, is available on the MHRA website (www.mhra.gov.uk). Health professionals are encouraged to report all suspected adverse drug reactions using this method, although hard copy Yellow Cards are also acceptable (and can be found bound to the back of the British National Formulary). The supplementary prescriber should also inform the independent prescriber of any reported ADRs.

65. The bulletin "Current Problems In Pharmacovigilance", issued by the MHRA and the CSM, contains advice and information on drug safety issues. The bulletin is produced four times a year. All supplementary prescribers are encouraged to consult the bulletin as a matter of routine. Copies are also available from the CSM's website, which can be found on www.mhra.gov.uk

Legal and Clinical Liability

Liability of employer

66. Where a nurse 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 supplementary prescribers are individually professionally accountable to the Nursing and Midwifery Council (NMC) for this aspect of their practice, as for any other, and must act at all times in accordance with the NMC Code of Professional Conduct. Pharmacists supplementary prescribers are individually accountable to the PSNI and must at all times act in accordance with the PSNI Code of Ethics and Practice Guidelines.

Professional indemnity

67. All supplementary prescribers should ensure that they have professional indemnity insurance, for instance by means of membership of a professional organisation or trade union.

Dispensing of prescribed items

Dispensing Doctors in primary care

68. Where a GP practice is a dispensing practice, prescriptions from supplementary prescribers can be dispensed by the practice but only for the dispensing patients of that practice. Dispensing Doctors cannot dispense prescriptions written by supplementary prescribers for patients of other practices.

Role of the pharmacist in dispensing pharmacist supplementary prescribers' prescriptions

69. The Department of Health, Social Services and Public Safety would normally expect separation of prescribing and dispensing roles where this is feasible, in keeping with the principles of safety, and clinical and corporate governance. However, in the context of supplementary prescribing, dispensing and prescribing need not necessarily be separated, provided clear accountability arrangements are in place to assure patient safety and probity.

70. The rules for dispensing and reimbursement of supplementary prescribers' prescriptions are the same as for GP prescriptions. Pharmacists should ensure that the cipher number is appropriately marked to ensure that it is a supplementary prescription, not an extended independent nurse prescription otherwise the cost of the prescription will not be reimbursed by CSA.

71. When sorting prescription forms prior to sending them to the CSA, community pharmacies should follow the sorting instructions on the prescription invoice - Form HS30.

Verification of prescribing status

Role of the pharmacist on verification of prescribing status

72. Dispensing pharmacists should ensure that they know the local procedure for resolving any queries with the supplementary prescriber or their independent prescriber partner.

73. To enable pharmacists to check whether a prescription handed in for dispensing is *bona fide*, all HPSS employers should keep a list of all supplementary prescribers employed by them. It is also recommended that the employing authority holds a copy of the prescriber's signature. Individuals

should be prepared to provide specimen signatures to pharmacists, should that be required. Dispensing pharmacists will be expected to use due diligence when dealing with prescriptions issued by supplementary prescribers

Dispensing by appliance contractors

74. When a supplementary prescriber becomes aware that the patient intends to have a prescription dispensed by an appliance contractor, they must ensure that the prescription does not contain medicinal preparations. When sorting prescription forms prior to sending them to the CSA, appliance contractors should follow the sorting instructions on form HS 30

Urgent dispensing

75. Occasionally prescriptions may require dispensing out of normal pharmacy opening hours. The prescription form should be endorsed by the prescriber with the word "Urgent". A pharmacist may claim an additional fee for dispensing a prescription urgently.

Dispensing of items in England, Wales and Scotland

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

Dispensing items against a nurse/pharmacist prescription in hospital pharmacies

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

Budget Setting and Monitoring

Supplementary prescribing monitoring information

78. The CSA reimburses costs to dispensing contractors and provides essential information, both electronically and via paper reports, to authorised users. Prescribing by nurse or pharmacist supplementary prescribers in primary care will be identifiable in CSA information systems where appropriate. Supplementary Prescribers in primary care can expect to receive information via their HPSS Boards, which will help to monitor their prescribing. Requests from the supplementary prescriber's employer should be made on headed notepaper to individual HPSS Boards.

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

Annex A

NURSING & MIDWIFERY COUNCIL

The Council's requirements for Extended independent nurse prescribing and supplementary prescribing

Standard of programme

1 The standard of the programme should be no less than first degree level, such as to enable the registered nurse, midwife or health visitor, from parts 1, 3, 5, 8, 10, 11, 12, 13, 14 and 15, to acquire the competencies which are set out in section 8 of this paper.

2 A variety of assessment strategies should be employed to test knowledge and the application of theory to practice.

3 Assessment should focus upon the principles and practice of prescribing and, professional accountability and responsibility of the practitioners on the Council's register undertaking the role.

Kind of programme

4 The post-registration programme should be free-standing to meet the required competencies in practice.

5 Arrangements must be in place for teaching, supervision, support and assessment of the student prescriber in practice.

Content of the programme

6 Pre-programme preparation:

6.1 each individual registered nurse's, midwife's or health visitor's previous education, training and experience will influence the amount of pre-programme preparation required before embarking on the prescribing programme at academic level 3

6.2 institutions may offer assessment of prior (experiential) learning (AP(E)L) to accommodate those who are currently prescribing or, who may be able to demonstrate learning that is appropriate, to meet some of the competencies required of this standard.

7 Content of the programme:

7.1 the content of the programme should reflect that prescribing is a competence based professional activity. The underpinning knowledge requirements and competencies are outlined in Section 8 of this paper

7.2 the content should reflect the requirements of local commissioners across the four countries of the United Kingdom in addition to those specified in this standard.

8 The principal areas, knowledge and competencies required to underpin the practice of prescribing.

Principal areas	Knowledge	Competence
Principles	• Legislation that underpins prescribing	• Works within the legislative framework relevant to the area of practice and locality
		• Understands the principles behind supplementary prescribing and how they are applied to practice
		• Able to use the adverse reaction reporting mechanisms
	• Team working principles and practice	• Awareness of the impact of prescribing in the wider delivery of care.
		• Able to work and communicate as part of a multidisciplinary prescribing workforce
		• *Reviews diagnosis and generates treatment options within the clinical treatment management plan*
	• Philosophy and psychology of prescribing	• Understand the complexity of the external demands and influences on prescribing

Practice	• Up to date clinical and pharmaceutical knowledge	• Makes an accurate assessment and diagnosis and generates treatment options
		• *Relevant to own area of expertise*
		• Able to prescribe safely, appropriately and cost effectively
	• Principles of drug dosage, side effects, reactions and interactions	• *Understands how medicines are licensed, monitored*
		• Able to work with patients and clients as partners in treatment
	• Communication, consent and concordance	• Proactively develops dynamic clinical management plans
		• Able to assess when to prescribe or make appropriate referral
		• *Able to refer back to a medical practitioner when appropriate.*
	• Relationship of public health requirements to prescribing	• Aware of policies that have an impact on public health and influence prescribing practice
		• Able to articulate the boundaries of prescribing practice in relation to the duty of care to patients and society

Principal areas	Knowledge	Competence
Accountability	• The Code of professional conduct.	• Able to apply the principles of accountability to prescribing practice
		• Able to account for the cost and effects of prescribing practice
	• The lines of accountability at all levels for prescribing	• Regularly reviews evidence behind therapeutic strategies
		• Able to assess risk to the public of inappropriate use of prescribed substances
	• Drug abuse and the potential for misuse	• Understand where and how to access and use patient / client records
	• Requirements of record keeping	• Able to write and maintain coherent records of prescribing practice
		• Able to communicate effectively with patients, clients and professional colleagues
	• Lines of communication	

Responsibility	• Leadership skills	• Able to advise and guide peers in the practice of prescribing
	• Roles of other prescribers	• Able to articulate and understand the roles of other key stakeholders in prescribing practice
	• Relationship of prescribers to pharmacists	• Understand the requirements of pharmacists in the prescribing and supply process
	• Clinical governance requirements in prescribing practice	• Link prescribing practice with evidence base, employer requirements and local formularies
	• Audit trails to inform prescribing practice	• Demonstrate ability to audit practice, undertake reflective practice and identify continuing professional development needs

Annex B

The Pharmaceutical Society of Northern Ireland
Outline Curriculum for Training Programmes to prepare Pharmacist Supplementary Prescribers

(This document has been adapted with permission from the outline curriculum of the Royal Pharmaceutical Society of Great Britain)

Introduction and Background

This curriculum contains the specification for programmes of study to prepare pharmacists to register as supplementary prescribers. It builds on the strengths in theoretical and applied therapeutics which pharmacists acquire from their initial training and through experience in practice. From the summer of 2002, newly registered pharmacists will have been educated on a four-year degree programme to 'Master's' level. Undergraduate education and training programmes give pharmacists a strong foundation in pharmacodynamics, pharmacology, pharmacokinetics and toxicity of medicines, and how they may be used to prevent and treat illness, relieve symptoms or assist in the diagnosis of disease. This is underpinned by knowledge of the law relating to pharmacy and medicines and its application together with supervised experience of working with patients. Once qualified, many pharmacists undertake additional postgraduate clinical training at Masters level.

The level of relevant knowledge and expertise of pharmacists entering a training programme will depend on the nature of their practice and the length of their experience. The design and delivery of programmes will need to take account of the range of pharmacists' background expertise, experience and skills and will be expected to confirm their competence in prescribing through appropriate assessment strategies.

The Pharmaceutical Society of Northern Ireland's Code of Ethics and Practice Guidelines requires that pharmacists ensure that their knowledge, skills and performance are of a high quality, up to date, and relevant to their field of practice. Pharmacists who register as Supplementary Prescribers will need to demonstrate evidence of relevant Continuing Professional Development to ensure that their prescribing skills are kept up to date and are extended as their prescribing role develops.

ENTRY REQUIREMENTS

All entrants to this education programme must meet the following requirements:

- Current registration with The Pharmaceutical Society of Northern Ireland
- Support from the sponsoring organisation e.g. Local Health and Social Care Group or Health & Social Services Trust, including confirmation that the entrant will have appropriate supervised practice in the clinical area in which they are expected to prescribe and that there is an identified service need for this extension of role.
- Have a named medical practitioner, recognised by the employing/Health Service commissioning organization a) as having experience in a relevant field of practice, b) training and experience in the supervision, support and assessment of trainees, c) who has agreed to;

- provide the student with opportunities to develop competencies in prescribing
- supervise, support and assess the student during their clinical placement.

Pharmacists would normally be expected to complete the full training programme. All candidates, however, would be required to complete all assessments, including satisfactory completion of the period of learning in practice.

AIM

To prepare pharmacists to practise as supplementary prescribers and to meet the standards set by the Pharmaceutical Society of Northern Ireland.

LEARNING OUTCOMES

By the end of the training programme, pharmacists will be able to:

- Develop an effective relationship with the Independent Prescriber, patient and wider care team
- Demonstrate their ability to communicate and consult effectively with patients and carers
- Demonstrate their ability to conduct a relevant physical examination of patients with those conditions for which they may prescribe.
- Demonstrate the ability to monitor response to therapy and modify treatment or refer the patient as appropriate.
- Demonstrate how to assess patients' needs for medicines, taking account of their wishes and values in prescribing decisions
- Demonstrate how they will prescribe safely, appropriately, clinically and cost effectively
- Identify sources of information, advice and decision support and explain how they will use them in prescribing practice taking into account evidence based practice and national / local guidelines;
- Recognise, evaluate and respond to influences on prescribing practice at individual, local and national levels;
- Develop and document a clinical management plan within the context of a prescribing partnership
- Demonstrate an understanding of the legal and professional framework for accountability and responsibility in relation to supplementary prescribing.
- Demonstrate a reflective approach to continuing professional development of prescribing practice

INDICATIVE CONTENT

It is expected that education providers will use the indicative content to develop a detailed programme of study which will enable pharmacists to meet the learning outcomes.

Consultation and Decision-Making

- Accurate and effective communication and consultation with professionals, patients and their carers
- Building and maintaining an effective relationship with patients, parents and carers taking into account their values and beliefs
- Understands own limitations
- A knowledge of the range of models of consultation and their applications
- Development and documentation of a clinical management plan including referral to the independent prescriber and other professionals
- Principles of diagnosis and the concept of a working diagnosis.
- Management options including non-drug treatment

Influences on and Psychology of Prescribing

- Patient demand versus patient need including partnership in medicine taking, awareness of cultural and ethnic needs.
- External influences, at individual, local and national levels.
- Awareness of own personal attitude and its influence on prescribing practice.

Prescribing in a Team Context

- The role and functions of other team members
- The responsibility of the supplementary prescriber in developing and delivering the clinical management plan.
- The professional relationship between independent and supplementary prescribers and those responsible for dispensing.
- Documentation, and the purpose of records in communicating prescribing decisions to other members of the team.
- Structure, content and interpretation of medical records/clinical notes including electronic health records
- Interface between multiple prescribers and the management of potential conflict
- The framework for prescribing budgets and cost effective prescribing

Update on relevant aspects of Basic and Applied Therapeutics

- Clinical pharmacology
- Basic principles of drug handling - absorption, distribution, metabolism and excretion
- Pharmacodynamics and pharmacokinetics
- Changes in physiology and drug response, for example the elderly, young, pregnant or breast feeding women and ethnicity
- Adverse drug reactions and interactions
- Pathophysiology of defined conditions for which the pharmacist may prescribe.
- Selection of drug regimen
- Natural history and progression of defined conditions.
- Impact of co-morbidities on prescribing and patient management

Principles and methods of monitoring

- Principles and methods of patient monitoring
- Chemical and biochemical methods for monitoring the treatment of the conditions for which the pharmacist may prescribe.
- Physical examination skills relevant to the conditions for which the pharmacist may prescribe.
- Assessing responses to treatment against the objectives of the clinical management plan
- Working knowledge of any monitoring equipment used within the context of the clinical management plan
- Patient compliance
- Identifying and reporting adverse drug reactions

Evidence-based Practice and Clinical & Social Care Governance in relation to Supplementary Prescribing

- The rationale for national and local guidelines, protocols, policies, decision support systems and formularies - understanding the implications of adherence to and deviation from such guidance
- Supplementary prescribing in the context of the local health economy e.g. application of local priorities to supplementary prescribing, prescribing guidance produced by Area Health and Social Services Boards and Local Health and Social Care Groups and Area Prescribing Committees.
- Principles of evidence-based practice and critical appraisal skills
- Reflective practice and continuing professional development - role of self and organisation
- Auditing, monitoring and evaluating prescribing practice
- Risk assessment and risk management

- Audit and systems monitoring
- Analysis and learning from medication errors and near misses

Legal, Policy, Professional and Ethical Aspects

- Policy context for prescribing
- PSNI Code of Ethics and Practice Guidance
- Legal basis for prescribing, supply and administration of medicines
- Medicines regulatory framework including Marketing Authorisation, the use of unlicensed medicines and "off-label" use.
- Application of the law in practice, professional judgment, liability and indemnity
- Maintenance of professional knowledge and competence in relation to the conditions for which the pharmacist may prescribe.
- Accountability and responsibility as a supplementary prescriber
- Accountability and responsibility to the employer or commissioning organisation, awareness of local complaints procedures
- Informed consent
- Prescription pad security and procedures when pads are lost or stolen
- Writing prescriptions
- Record keeping, documentation and professional responsibility
- Confidentiality, Caldicott and Data Protection
- Suspicion, awareness and reporting of fraud or criminal behaviour, knowledge of reporting and 'whistle blowing' procedures

Prescribing in the Public Health Context

- Duty to patients and society
- Public health policies, for example the use of antibiotics
- Inappropriate use of medicines including misuse, under and over-use
- Inappropriate prescribing, over and under-prescribing

TEACHING, LEARNING AND SUPPORT STRATEGIES

Teaching and learning strategies need to recognise:

- the background knowledge and experience of pharmacists in all aspects of medicines, working with patients and the law relating to pharmacy and that this will vary between individuals
- the requirement for a pharmacist to become familiar with the specified conditions for which they may prescribe and that some individual directed study may be necessary to achieve this.
- the value added to learning by group work and multi-disciplinary learning experiences with other trainee supplementary prescribers
- the value of case studies and significant event analysis in the learning process.
- the need to encourage development of critical thinking skills and reflective practice and the maintenance of CPD records

Period of Learning in Practice

The sponsoring organisation e.g. Local Health & Social Care Group or HPSS Trust, and the education provider must ensure that the designated medical practitioner who provides supervision, support and shadowing opportunities for the student is familiar with the requirements of the programme and the need to achieve the learning outcomes. In particular, this element of the programme should ensure that;

- The pharmacist becomes competent in the relevant physical examination of patients with those conditions for which they may prescribe
- The pharmacist is able to monitor and assess the responses of patients to treatment against the objectives in the clinical management plan.
- The pharmacist demonstrates effective communication with the patient, the independent prescriber and the wider care team.
- The pharmacist keeps adequate records of their prescribing practice.
- The pharmacist demonstrates and documents his/her professional development as a supplementary prescriber.

ASSESSMENT STRATEGIES

The assessment requirements must be made explicit, in particular the criteria for pass/fail and the details of the marking scheme.

Assessment should test all aspects of supplementary prescribing, both theory and practice The learning outcomes should be assessed by a combination of methods to test knowledge, skills and a reflective approach to the continuing professional development of prescribing practice (e.g. by written examination, OSCE, reflective journal) Each student should maintain a portfolio of assessment and achievement of the stated learning outcomes.

The assessment strategies should test:

a) Knowledge and skills relevant to supplementary prescribing

b) Ability to work with patients and make prescribing decisions

c) Ability to conduct the relevant physical examination of patients for whom they can prescribe

d) A reflective approach to learning and CPD as a supplementary prescriber

e) Satisfactory completion of the period of practice experience*

*Completion of the programme and confirmation of an award must be conditional on satisfactory completion of the practice experience. Poor performance in this element must not be compensated by other elements of the assessment.

LENGTH OF PROGRAMME

The duration of the programme is expected to be at least 25 days, of which a substantial proportion will be face-to-face contact time. Other ways of learning, such as open learning formats will be considered. In finalising programme requirements for this curriculum, the following factors will be taken into account;

- The views of education providers on a realistic programme length to deliver the curriculum effectively over a period of three to six months. Current practice in training nurse prescribers is approximately 27 days contact time over six months plus the equivalent of one day per week learning in practice. A total of approximately 37 days.
- The compatibility of programmes for nurses, pharmacists and supplementary prescribers from other disciplines so that at least some of the learning experiences are shared

- The need for programmes for pharmacists to contain an element of directed private study on the defined conditions for which they will be expected to prescribe treatments.
- The period of learning in practice for an individual pharmacist should be sufficiently long to enable the pharmacist to become competent in the skills of supplementary prescribing practice and in no case should it be less than 12 days.
- The 'learning in practice' period should be completed within twelve months of the taught element of the course.
- It is preferable to mix the taught element with supervised practice.

ANNEX C

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

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

Agreed by independent prescriber(s)	Date	Agreed by supplementary prescriber(s)	Date	Date agreed with patient/carer

ANNEX D

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

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

ANNEX E

NOTIFICATION OF PRESCRIBER DETAILS TO CSA

1. The details of supplementary prescribers employed by a Community HPSS Trust or independent contractor must be registered with the Central Services Agency (CSA) before prescriptions for that prescriber can be ordered. There is currently no requirement to notify the CSA of changes to the details of hospital-based supplementary prescribers (see also Annex F).

2. Notification of required details by the prescribers' employer or HPSS Board to the Central Services Agency (CSA) enables the setting up of automatic monitoring processes as well as allowing the provision of prescriber details (currently primary care prescribers only) to the supplier (currently De La Rue Smurfit) for the printing of prescription pads.

   - Employers of all supplementary prescribers practising in primary care are therefore required to inform the CSA of the supplementary prescriber.

3. The CSA Annex forms should also be used to notify the CSA of changes in circumstances (e.g. name) as they occur.
   - In order to avoid transposition errors, and the subsequent problems incurred, the CSA Annex forms should be completed electronically by the relevant personnel within each HPSS Board Primary Care Trust and Community Trust and then e-mailed to CSA (At date of publication the electronic system is not in place and is anticipated to be in place in early 2004).

4. The detail asked for on the CSA Annex forms has been kept to a minimum to reduce work for the employer. Collecting and transmitting the information will, however, require co-operation and this should ideally be discussed at the implementation stage, if such systems are not already in place. The details asked for on the CSA Annex forms include the:
   - supplementary prescriber's "personal identification number" - provided by the NMC or PSNI.
   - supplementary prescriber's name and profession (nurse or pharmacist)
   - organisation for which the supplementary prescriber works (where relevant)
   - organisation details

Changes to prescriber details

5. It is the responsibility of employers of supplementary prescribers who have been notified to the CSA to ensure that changes to the prescriber's details are reported to CSA as soon as they occur, e.g. change of name on marriage, change of telephone number. Failure to do this will mean that prescription forms will continue to be produced with the former (incorrect) details on them.

6. It is the responsibility of independent contractor employers of supplementary prescribers in primary care, and any community pharmacists acting as supplementary prescribers, to pass details to the CSA within 48 hours (excluding weekends or Bank Holidays) of any changes.

Prescriber ceases employment / prescribing.

7. The employer, or the HPSS Board in the case of independent contractors, should inform the CSA as soon as possible when a nurse prescriber or pharmacist supplementary prescriber is no longer carrying out prescribing duties (for example, because he/she has changed employer, been suspended from the register or had his/her approval as a prescriber withdrawn for some reason). They should do this by submitting the relevant CSA Annex form. This includes circumstances where the employer is contracted to provide services for other commissioning organisations, e.g. nursing services through a Community Nurse Prescribing Contract.

8. The CSA will keep an annotated lists of supplementary prescribers on behalf of the HPSS Boards and will ensure that an up-to-date record exists.

ANNEX F

PRESCRIPTION FORMS

1. All prescription forms require information to be entered on them (by printing or writing or 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 and to the correct prescribing budget.

PRESCRIBING IN PRIMARY CARE

Ordering prescription forms

2. Employers should note that prescription forms are not sent out automatically. HS21N prescription forms must be ordered from the supplier (De La Rue Smurfit). Prescriptions should also be re-ordered from De La Rue Smufit as and when required.

3. Orders for new prescribers' prescription forms should not be placed earlier than 42 days prior to the date the individual is scheduled to begin prescribing for your organisation, as De La Rue Smufit cannot access CSA data before this point.

4. 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. Details on orders must match CSA data held by 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.

5. Prescriptions are normally sent to the address of the person who orders them (you can specify an alternative address for invoicing purposes). Difficulties with prescription orders should be addressed, in the first instance, to De La Rue Smurfit. Supplementary prescribers should check that the details on the prescription form are correct and that the correct quantity of forms have been received.

Prescription forms HS21N

6. Prescription forms for pharmacist supplementary prescribing will be overprinted with one cipher number. Prescription forms for nurse prescribing will be overprinted with two cipher numbers that will identify the nurse (4 digit number) and the prescribing area S for supplementary and E for extended prescribing e.g: 1234 (S) 4567 (E)

7. The address box will be overprinted to identify:

- the supplementary prescriber,
- the practice they are prescribing on behalf of.

Any prescriber who works for more than one employer or in more than one setting e.g. a nurse attached to more than one GP practice must have a separate prescription for each practice/organisation, with the correct practice/organisation in the address box area of the prescription form.

PRESCRIBING BY HOSPITAL BASED SUPPLEMENTARY PRESCRIBERS

8. Supplementary prescribers prescribing for hospital in-patients and discharge patients must use the relevant hospital prescription form or sheet.

9. There is currently no requirement to notify the CSA of changes to the details of hospital-based supplementary prescribers

NON-HPSS EMPLOYEES

10. A non-HPSS supplementary prescriber cannot issue an HS21N type prescription, i.e. one which will be dispensed in a community pharmacy, unless the organisation they work for has an arrangement / contract with a HPSS provider (e.g.LHSCG) which allows the non-HPSS organisation to use HPSS community pharmacy dispensing services. The HPSS provider should organise the supply of HS21N type prescription forms (and obtain the prescribing code(s) to be used) for the non-HPSS organisation, if this is appropriate.

HOW TO COMPLETE THE PRESCRIPTION FORM

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

12. 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:

- the patient's title, forename, surname and address (including postcode) and if available the patient's HPSS number.
- Age and date of birth (should be printed by computer prescribing systems; for hand written prescriptions - enter if known e.g. from patient notes - BUT 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) and special containers and the quantity contained should be prescribed, provided this is clinically and economically appropriate. The quantity should be specified for solid preparations as number of dose-units (number of tablets, capsules, lozenges, patches etc), for liquid measures in millilitres (mL or ml), for topical preparations by mass (grams, g) or volume (millilitres, mL 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 discharge prescriptions, the requirements are the same, whilst recognising local policies for example on the length of treatment provided for patients who are being discharged.
- The names of medicines should be written clearly. Nurses and pharmacists are recommended to prescribe generically, except where this would not be clinically appropriate or where there is no approved generic name - see the Nurse Prescribers' Formulary for District Nurses and

Health Visitors, the Nurse Prescribers' Extended Formulary, the BNF and the Drug Tariff. Names of medicines and generic titles should not be abbreviated. Exceptions to this rule are for the prescribing of some dressings and appliances, and of compound or modified release medicines which have no approved non-proprietary name.

- directions, which should be in English and not abbreviated
- where there is more than one item on a form, a line should be inserted between each item for clarity
- unused space in the prescription area of the form should be blocked out with, for example, a diagonal line (to prevent subsequent fraudulent addition of extra items)
- prescribers' signature and date
- on hospital prescriptions only: the nurse's / pharmacist'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

13. 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).

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

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

16. 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.

17. 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 placed in a locked drawer.

18. Best practice recommends that where possible, all unused forms should be returned to stock at the end of the session or day. Prescriptions are less likely to be stolen from (locked) secure stationery cupboards than from desks, bags or cars.

Loss of prescription forms

19. 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.

20. All prescribers working in primary care should report any loss or theft of prescription forms to CSA (telephone 028 90324431) as soon as possible after the theft/loss is confirmed. The prescriber should give details of the approximate number of scripts stolen, their identification numbers, and where and when they were stolen.

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

22. Following the reported loss of a prescription form, the CSA will inform all pharmacies in their area and adjacent HPSS Board of the name and address of the prescriber concerned; the approximate number of scripts stolen. This will normally be put in writing within 24 hours with the exception of weekends.

23. In the event of a loss or suspected theft, an HS trust-employed prescriber should report this immediately to whoever issued the prescription forms. The prescriber should give details of the number of scripts stolen, their serial numbers, and where and when they were stolen. Thereafter, \Trust-based prescribers should follow local instructions following the loss or theft of prescription forms.

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

- prescription pads are retrieved from supplementary 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 supplementary prescribers have left employment would still be charged to the appropriate budget.

- to ensure that no further prescription pads are ordered for a prescriber who has left their employment or who has been suspended from prescribing duties, and
- to recover, record and securely destroy all unused prescription forms relating to that prescriber.
- To notify CSA that the prescriber is no longer employed.

NB All of the above requirements highlight the need for clear channels of communication, particularly between GP practices/ and HPSS Boards.

ANNEX G

Extended Independent and Supplementary Prescribing Training Programme for Nurses, Midwives & Health Visitors

This programme will prepare suitably qualified nurses, midwives and health visitors for the extended roles of Independent and supplementary Prescribing.

- Independent Prescribing is when the practitioners have the authority for prescribing, within the specified list of drugs, in their own right as Independent Prescribers.
- Specified healthcare professionals may act as Supplementary Prescribers with delegated authority from medical staff to adjust prescriptions within agreed boundaries.

In both cases the practitioners are professionally accountable for their actions

THE COURSE: Independent and Supplementary Prescribing leads to one of the following:

- Certificate in Independent and Supplementary Prescribing
- 60 credits towards post-registration Undergraduate Nursing/Midwifery/Health degree
- Postgraduate Certificate in Independent and Supplementary Prescribing
- 60 credits towards Postgraduate Diploma at UU/QUB

The course consists of four modules of study:

- Professional Issues and Patient Empowerment in Prescribing
- Health Assessment for Non-Medical Prescribing
- Pharmacotherapeutics Across the Lifespan
- Specialised Prescribing

Students also complete the equivalent of 15 days clinical experience under the supervision of a qualified medical practitioner as mentor

Students will be required to achieve all the clinical competencies applicable to their level of study.

14 CRITERIA FOR ADMISSION TO THE NURSE PRESCRIBING COURSE

Applicants must satisfy the University's general entry requirements and specific requirements for admission to the course are detailed below:

The aim in selection of students to undertake the programme is to identify those who will successfully complete the course, demonstrate the necessary competencies, and be able to carry out the role of nurse prescriber within her/his normal work. Thus the following criteria were agreed for admission:

1. first level Registered Nurse or Midwife (on live NMC regisiter)

2. the ability to undertake academic study at degree level or above. This may be demonstrated through any of the following:

Undergraduate level

- Successful completion of the equivalent of three modules (60 credits) of study at level 2 with a mark of at least 50%. This will include evidence of the skills necessary for the implementation of evidence based practice (eg. through completion of a module on research or evidence based practice). [This requirement of 60 credits at level 2 could be met through the Preparation for Specialist Practice Programme offered by the In-Service Education Consortia, an Advanced Diploma, a Diploma in Higher Education, or a number of individual modules including the use of APEL.]

Postgraduate level

- Pre-registration degree in Nursing or Midwifery
- Post-registration degree or advanced diploma in Nursing, Midwifery or Health Studies/Sciences
- Degree in other subject area

3. working in an environment where they will be able to practice the necessary skills with the support of an identified medical mentor;

4. supported by their managers and the role that they will fill after completion of the programme has been agreed and will include prescribing;

5. access to a prescribing budget;

6. a background of specialist knowledge in their area of practice. This may be through completion of one of the following:

   - Community Nursing qualification
   - Specialist Nursing qualification
   - At least three years clinical experience with at least one of these within the area in which they will be prescribing. This will be supported by educational input specific to their area of practice which be assessed individually at the time of application.

7. be able to demonstrate access to a computer and the web for study.

FIGURE 1 INDEPENDENT AND SUPPLEMENTARY PRESCRIBING: COURSE PROGRAMME

Timescale	*Attendance at University*	*Taught Course Content*	*Competency Development*
Pre-course	1 day	**Professional Issues and Patient Empowerment in Prescribing (10 credit points)** — *Workbook and discussion*	
Week 1	2 days	*Orientation to course and learning methods*	
Weeks		**Pharmacotherapeutics Across the Lifespan (20 credit points)** — *elearning and case studies*; **Health Assessment for Non-Medical Prescribing (15 credit points)** — *elearning and skills practice with tutorial support*	***Working under the supervision of an approved mentor***
Weeks	3 days		Clinical observation and health assessment (3 days)
Weeks		*Workshop on prescribing*	Health assessment and prescribing (at least 12 days)
Weeks		**Specialised Prescribing (15 credit points)** — *Case Studies drawing on all parts of curriculum*	
Weeks	3 days	*elearning and independent study with specialist academic guidance*	
Weeks			
Week	1 day	*Completion of Coursework Assessment* *Review of Competency Manuals* *Review of Prescribing Procedures* *Evaluation of Programme* *Administration for Recording Qualification*	

Week 52	1 day	*Evaluation* *Up-dating* *Discussion of issues arising in practice*
Year 2 onwards	1 day per annum	*Regular Up-dating*

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