Extending Independent Nurse Prescribing within the NHS in England

A guide for implementation

March 2002

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Author	**Medicines Pharmacy & Industry Division, and Nursing and Midwifery Policy Branch Department of Health**
Further copies from NHS Response Line	**Telephone: 08701 555 455**
Date of Issue	**March 2002**
Catalogue Number (proposed)	

Record of Amendments		
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How to use the guide

This guide has been prepared for:

- NHS trusts
- Primary Care Trusts/Groups
- Personal Medical Services Pilots
- NHS Walk-in Centres
- General Practitioners
- Health Authorities
- DH Regional Offices
- Higher Educational Institutions providing nurse education

Other groups who will be interested in the guide, and who have therefore been sent a copy, include:

- Community Pharmacists
- Community Services Pharmacists employed by, or contracted to, NHS trusts
- Patient Groups

It will be for Primary Care Trusts and Groups, NHS Trusts and health authorities to decide, in light of local priorities and in consultation with DH Regional Nurse Prescribing Leads and local health professionals, which nurses in their area should undertake the preparation for prescribing from the extended formulary between 2002 and 2004. This guide has been prepared to assist them. Sections of the guide may be reproduced at local level for the information of individual nurses or other interested parties, as required.

Contents

Introduction

This guidance sets out the administrative or procedural steps that are needed to enable nurses and midwives to prescribe from the extended formulary, and provides information and advice on good practice. **[NB Where the term "nurse" is used in this document it includes Registered Midwives]**

Brief history of nurse prescribing in England

1 The nurse prescribing scheme for district nurses and health visitors was based on the recommendations contained in the Report of the Advisory Group on Nurse Prescribing 1989, which advised Ministers how patient care in the community might be improved by introducing nurse prescribing. The report identified a number of clear benefits that could arise from nurse prescribing:

- an improvement in patient care;
- better use of the patients', nurses' and GPs' time;
- clarification of professional responsibilities leading to improved communications between team members.

2 Following the introduction of the necessary legislation[1], nurse prescribing was first piloted in eight GP fundholding practices in 1994, was extended to a whole district community NHS Trust in 1996[2] and to a further community trust in each of the seven remaining regions in 1997.

3 Following successful piloting, Ministers agreed that the nurse prescribing scheme could be extended in England. By September 2001, more than 22,000 qualified district nurses (DNs) and health visitors (HVs), including around 1,000 practice nurses who hold one of these qualifications, had been

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[1] The Medicinal Products: Prescription by Nurses, etc. Act 1992 [which amended the National Health Service Act 1977 (section 41) and the Medicines Act 1968 (section 58)];
The Medicinal Products: Prescription by Nurses, etc Act 1992 (Commencement No 1) Order 1994;
The National Health Service (Pharmaceutical Services and Charges for Drugs and Appliances) Amendment Regulations 1994 [which amended the NHS (Pharmaceutical Services) Regulations 1992 and the NHS (Charges for Drugs and Appliances) Regulations 1999).

[2] The National Health Service (Charges for Drugs and Appliances) Amendment Regulations 1996

trained to prescribe from the Nurse Prescribers' Formulary (NPF). The prescribing course is now integrated into University-based specialist practitioner programmes for new district nurses and health visitors.

Extending nurse prescribing

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

- Minor ailments
- Minor injuries
- Health promotion
- 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 will be able to prescribe all General Sales List and Pharmacy medicines currently prescribable by GPs under GPMS regulations, with the exception of those products which contain controlled drugs, together with a list of Prescription Only Medicines (POMs). £10 million of central funding is allocated over the period 2001-2004 to train around 10,000 nurse prescribers.

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.

Current nurse prescribers

8 DN and HV prescribers will continue to be able to prescribe from the current Nurse Prescribers' Formulary, which is tailored to their needs. It will be regularly reviewed to keep it up-to-date and in line with the practice requirements of this

professional group. DNs and HVs will also be eligible for consideration for training to qualify as prescribers from the Extended Formulary, where there is a service need for them to do so. Higher Education Institutions offering the specific programme of preparation for the Extended Formulary may accredit the nurse prescriber's prior learning.

Scope of this guidance and effect of devolution

9 This guidance sets out the steps to implement extended nurse prescribing in England. Although the legislation that permits the extension of prescribing applies across the UK, it is for the devolved administrations in Scotland, Wales and Northern Ireland to decide whether and how to implement nurse prescribing in their countries.

Who may prescribe and what may be prescribed in extended nurse prescribing

Categories of nurses and midwives who may prescribe

10 Planned amendments to the Prescription Only Medicines (POM) Order, NHS Pharmaceutical Services Regulations and NHS Charges Regulations will mean that it will not be necessary for a nurse to hold a district nursing or health visiting qualification in order to prescribe from the Nurse Prescribers' Extended Formulary, or to be eligible to undertake the specific programme of preparation.

11 To be legally eligible to prescribe from the Extended Formulary following the proposed amendments to the POM Order and NHS regulations:-

(a) Prescribers must be a 1st level Registered Nurse or Registered Midwife; and

(b) In each case the nurse's or midwife's name must be held on the UKCC[3] professional register with an annotation signifying that the nurse has successfully completed the specific programme of preparation for extended nurse prescribing approved by the English National Board for Nursing, Midwifery and Health Visiting (or successor body), and is qualified to order medicines from the Extended Formulary, and devices, for patients.

[3] References throughout these Guidelines to the UKCC should be read as referring to the Nursing and Midwifery Council from April 2002

12 DH plans to bring the revised regulations into force to enable the first nurses to be able to prescribe from the extended formulary from 1 April 2002. We will circulate details of the revised regulations as soon as these are laid.

Nurse Prescribers' 'Extended Formulary' and Drug Tariff

13 Nurses who have undergone extended training to prescribe may only prescribe on the NHS from the items listed in the Nurse Prescribers' Extended Formulary (NPEF) or the NPF. The list will be published monthly in the Drug Tariff and incorporated every six months into the British National Formulary (BNF). Nurses able to prescribe from the Extended Formulary will receive a centrally funded copy of the BNF every six months. The Nurse Prescribers' Formulary for district nurse and health visitor prescribers will continue to be published biennially with amendments published annually. [This will also be made available to nurses prescribing from the Extended Formulary]. A copy of the Drug Tariff will be supplied to all nurse prescribers every six months by the Prescription Pricing Authority (PPA). NB The Drug Tariff is produced every month and nurse prescribers should have access to an up-to-date copy, if required.

14 Nurse prescribers should not prescribe medicines for uses outside of their licensed indications ('off licence'). Guidance in the Nurse Prescribers' Extended Formulary will list the indications for which nurses may prescribe each medicine. Nurses' prescribing may also be limited by locally agreed formularies. In prescribing as in other areas of practice, nurses and midwives are bound by the UKCC Scope of Professional Practice to act only within their competence, and for this reason many practitioners will not prescribe from all sections of the NPEF.

15 The extension of nurse prescribing to include midwives does not affect the exemptions under Medicines Act legislation, which allow midwives to supply or administer certain listed medicines.

16 Nurses may continue to use Patient Group Directions for the supply of medicines, *where this is a more appropriate response to patients' needs*.

Implementation strategy

Selection of nurses and midwives to be trained

17 The selection of individuals who will receive prescribing training from amongst those eligible will be a matter for local decision in the light of local NHS needs and circumstances. It is likely that early candidates will include nurse consultants, nurse practitioners and specialist practitioners. No nurse shall be required to undertake training unless he/she wishes to do so.

18 In addition to fulfilling the legal criteria for eligibility to prescribe, applicants for the prescribing preparation will need:

- The ability to study at level 3 (degree level)
- At least three years post-registration clinical nursing experience (or part-time equivalent): nominees will usually be at E grade or above
- A medical prescriber willing to contribute to and supervise the nurse's 12 day learning in practice element of preparation (see below)
- The support of their employer to confirm that
  - their post is one in which they will have the need and opportunity to prescribe from the NPEF;
  - for nurses in primary care, they will have access to a prescribing budget on completion of the course
  - they will have access to continuing professional development (CPD) opportunities on completion of the course.

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

- patient safety
- maximum benefit to patients in terms of quicker and more efficient access to medicines for patients
- better use of nurses' skills

20 The extension of nurse prescribing is intended to extend the benefits of nurse prescribing beyond community and primary care, and it is expected that nominees for the centrally-funded preparation will come from secondary care as well as primary care settings.

DH Regional Nurse Prescribing Leads

21 DH Regional Nurse Prescribing Leads can advise NHS employers on the application of these criteria. They will liaise between local health economies, Workforce Development Confederations and Higher Education Institutions to ensure that applicants and course places can be appropriately matched.

Central funding for extending nurse prescribing

22 Central funding will be made available through Workforce Development Confederations to train nurses in prescribing. This will be allocated to a lead Confederation in each NHS region on the basis of the numbers of qualified nurses, midwives and health visitors in the workforce[4] in the Region. Central funding is only available to meet the cost of prescribing training for nurses, midwives and health visitors. Other costs (e.g. the cost of providing cover while the nurse is studying on the course) will be the responsibility of the employer.

23 The central funding allocated for the extension of nurse prescribing is intended to benefit patients and their access to medicines in the NHS. Training for nurses employed by NHS bodies (including Primary Care Trusts, GP practices, Personal Medical Services pilots, NHS Trusts and NHS Walk-in Centres amongst others) can therefore be funded from this resource.

Non-NHS staff

24 Nurses employed by non-NHS organisations, and who provide the majority of their services to NHS patients (e.g. nurses working in hospices) may also have their training funded from central funds.

25 In nominating for training any nurses whose posts are directly or indirectly funded by pharmaceutical and other companies whose products may appear in the Nurse Prescribers' Extended Formulary, employers should be aware of, and take any necessary steps to ameliorate, any conflicts of interests that may subsequently arise in the nurse's practice. Nurses are reminded

[4] Figures taken from the Department of Health Hospital and Community Services Non-medical Workforce Census Sept 2000 and GMS Workforce statistics

of clause 16 in the 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'.

Funding from other sources

26 There is no reason why an NHS organisation or private organisation should not pay for the preparation of more nurses and midwives by identifying other sources of funding (e.g. existing training budgets). But see para 52 re non-NHS nurses using NHS community pharmacy dispensing services.

Education and Training

The programme of preparation for extended nurse prescribing

27 Nurses, midwives and health visitors preparing for extended nurse prescribing will undertake a specific programme of preparation at degree level (level three). The programme will include 25 taught days in a University plus 12 days 'learning in practice', when a designated supervising medical practitioner will provide the student with supervision, support and opportunities to develop competence in prescribing practice. The nurse will need to have regular contact with the doctor during this 12 day period. More details are at Annex C. An additional element of self-directed learning will also be needed.

28 The programme will be part-time over a period of three months. Whilst the formal programme time is 37 days, it is important that employers of nurses undertaking the programme recognise the demands of private study, providing support where necessary. The Department of Health will review the length of the programme, once HEIs have experience of running it, with a view to considering delivery over a longer timescale.

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

30 The standards for the preparation for extended nurse prescribing have been set out by the UKCC[5]. 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.

31 An outline curriculum for the preparation for extended nurse prescribing was developed by a multi-disciplinary expert group. It was published under cover of an Education Policy Letter from the ENB in September 2001[6]. The training includes pharmacology, therapeutics, public health issues, practical aspects of prescribing and the safe and secure handling of medicines. It also includes the legal and financial aspects of nurse prescribing.

32 The ENB or its successor will approve Higher Education Institutions which apply to provide the specific programme of preparation. Nurses can *only* qualify to prescribe by attending an English National Board (ENB) approved nurse prescribers' programme of preparation.

Other training and education

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

Continuing Professional Development (CPD)

34 All nurses and midwives have a professional responsibility to keep themselves abreast of clinical and professional developments. This is no less true for nurse prescribing. 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 of the drugs, dressings and appliances on the Nurse Prescriber's Extended Formulary. They 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. Details of additional training

[5] Registrar's letter 25/2001 of 11 September 2001

[6] EPL 2001/01/TL of September 2001

and updating will need to be incorporated by the individual into their personal professional profile, in order to renew their registration with the UKCC. DH is commissioning a programme of CPD support for nurse prescribers through the National Prescribing Centre.

35 Nurse prescribing should be introduced and take place within a framework of clinical governance. Clinical supervision sessions 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, and should be monitored and evaluated regularly. During the pilot phase of nurse prescribing by DNs and HVs, pharmacists were extremely helpful in providing expert input into clinical supervision as well as CPD sessions for nurse prescribers.

36 The National Prescribing Centre has led the production of a document setting out a framework for assessing nurse prescribing *competencies*, using an iterative process which involved the input of both professional organisations and experienced nurse prescribers. This can be used by students of nurse prescribing, newly-qualified and more experienced nurse prescribers, their employers and managers, as a tool to assist in reflecting on practice and identifying CPD needs. This is available on the NPC's website www.npc.ppa.nhs.uk

Notification of qualification to prescribe to UKCC

37 Once the nurse or midwife has successfully completed the prescriber preparation, the UKCC will be notified by the ENB (until March 2002, but subsequently by the HEI). The individual's entry on the UKCC professional register will be annotated to indicate that she/he has qualified as a nurse prescriber for the Extended Formulary. A nurse 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 UKCC 24-hour Voice Bank telephone line[7] 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.

[7] Telephone number 020 7631 3200

Notification of nurse's/midwife's employer

38 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 one of the following actions:

Action for employers of nurses and midwives in primary care

39 Nurse employers will be required[8] to inform the Prescription Pricing Authority (PPA) of the nurse prescriber's details using one of the following proformas:
Annex A1 – For use by Community NHS Trusts for nurse or midwife prescriber details;
Annex A2 – For use by HAs for details of nurse or midwife prescribers employed by a practice or a PMS Pilot (this Annex will be used by PCTs from October 2002)
Annex A3 – For use by PCTs for details of nurse or midwife prescribers directly employed by the PCT (including circumstances where the PCT is contracted to provide nursing services to other commissioning organisations, through a Community Nurse Prescribing Contract).
This will also include notifying the PPA of changes in circumstances (e.g. name) as they occur. The revised versions of the forms will be available on the PPA website www.ppa.nhs.uk from February 2002. **[NB The example annex forms included in these guidelines do not truly reflect the spacing and font of those available on the PPA website. Organisations should therefore use the versions on the PPA website rather than copying and using those in this document as this may cause difficulties for the PPA when updating the PPA Information database].**
Primary Care Trusts should ensure that current HA/PPA liaison arrangements are continued by the PCT or PCT Agency (as appropriate).
Please note that there is no requirement for hospital based nurse prescribers to register with the PPA.

40 *GP Practice and PMS Pilots:* these employers should pass details to their Primary Care Trust within 48 hours (excluding weekends or Bank Holidays) of receiving notification of the

[8] Paragraph 8 of Schedule 2 to the NHS Act 1990 provides that "an NHS Trust shall furnish to the Secretary of State such reports, returns and other information, including information as to its forward planning, as, and in such form as, he may require". In this case the Secretary of State is intending to require NHS Trusts to furnish information direct to the Prescription Pricing Authority, in the manner prescribed on the official proforma.

nurse's qualification to prescribe or changes in circumstances (eg name). The Primary Care Trust will then be responsible for informing the PPA of GP practice (and PMS) nurse prescribers using the proforma shown at Annex A2. This responsibility also includes notifying PCTs of changes in a nurse prescribers' circumstances within 48 hours (not including weekends and Bank Holidays).

41 The information to be provided has been kept to a minimum in order to reduce work for the nurse's 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.

Obtaining prescription forms

42 Nurse employers should note that prescriptions are not sent out automatically. FP10 prescriptions must be ordered from the supplier (currently Astron).

- Community NHS Trust, HA, PCT or PMS pilot nurse *must be registered with the PPA* as the process of preparing the forms at Astron cannot begin until the prescriber details have been notified to the PPA. Early notification of such details is very important, in order that qualified nurses can begin utilising their new skills. However, orders for new prescribers should not be placed earlier than 42 days prior to the date the nurse or midwife is scheduled to begin prescribing, as Astron cannot access PPA data before this point.

- Managers of hospital based nurses should order FP10HP which will be supplied ready for hand stamping with nurse and hospital details. See para 51 for details of stamps required.

Prescriptions are normally sent to the address of the person who orders them (you can specify an alternative address for invoicing purposes). Checks are made to ensure that FP10 prescriptions are only supplied to bona-fide NHS organisations. Difficulties with prescription orders should be addressed, in the first instance, to Astron. See para 52 re supply of prescriptions to non-NHS nurses.

Role of the Prescription Pricing Authority (PPA) for prescribing in primary care

43 Notification of prescriber details to the PPA enables the setting up of the automatic monitoring processes in order that prescriptions written by nurse prescribers can be validated, as well as the provision of prescriber details to Astron.

44 Briefly, the details asked for on the proforma include:

- nurse's UKCC "personal identification number"
- nurse's name
- nurse's qualifications (DN/HV or Extended Formulary prescriber)
- organisation for which the nurse works
- organisation details

45 If a nurse prescriber is no longer carrying out prescribing duties (for example, because he/she has left the employment of the PCT or practice, been suspended from the register of nurses or had his/her approval as a prescriber withdrawn for some reason), PPA will need to be informed quickly either by the HA or the PCT for nurses employed by a Practice or a PMS Pilot, and via PCTs for nurses employed directly by the PCT. This includes circumstances where the PCT is contracted to provide nursing services to other commissioning organisations through a Community Nurse Prescribing Contract. The forms referred to in paragraph 39 above should be used to advise the PPA of this information.

46 This requirement highlights the need for clear channels of communication, particularly between GP practices/PMS pilots and PCTs. *It is the responsibility of the nurse's employer:*

- *to ensure that no further prescription pads are ordered for a nurse who has left employment or who has been suspended from prescribing duties*
- *to recover, record and securely destroy all unused prescription forms issued to that nurse relating to that employment*

HAs and PCTs should annotate their lists of nurse prescribers with the reasons for any changes, to ensure that an up to date record exists.

The Prescription Form

Prescription forms for nurses and midwives in primary care

47 Existing nurse prescribers may have FP10PN or FP10CN forms. In October 2001, production of these forms ceased. After this date, as pads are re-ordered, or obtained for new nurse prescribers, the forms supplied will be FP10P (lilac in colour) prescription forms. These will be annotated DISTRICT NURSE/HEALTH VISITOR PRESCRIBER. Any district nurse or health visitor prescribers using FP10CN or FP10PN should switch to FP10P by April 2002 *at the very latest*; any remaining FP10CN or PN forms should be securely destroyed as soon as replacement FP10Ps are received.

48 When the nurse qualifies to prescribe from the extended formulary the employer should order and give the nurse FP10P prescription forms annotated with EXTENDED FORMULARY NURSE PRESCRIBER.

49 Any nurse or midwife prescriber who works for more than one employer or in more than one setting e.g.

- 1 – PCT directly employed nurse or midwife prescriber providing services to those patients in the PCT.
- 2 – the same nurse providing services to patients external to the PCT through a Community Nurse Prescribing Contract.

must have a separate prescription pad for each organisation/scenario, with the correct organisation in the identification details area of the prescription form.

50 Nurses or midwives directly employed by Community NHS Trusts or PCTs working across different GP practices **can use one prescription pad** but must add the relevant practice number for each patient for whom they prescribe.

Prescribing by hospital based nurses and midwives.

51 Nurse prescribers prescribing for hospital in- or out-patients may use three methods to prescribe:

- Ward order – to be used for in-patients and discharge supplies only. A prescription charge is not levied on in-patients.

- Internal hospital prescription form – to be used for out patients *but only in cases where the hospital pharmacy will dispense the prescription*. A prescription charge may be payable, unless the patient is exempt from prescription charges. For this reason, these types of form often resemble an FP10 prescription form **(NB internal hospital forms cannot be accepted for dispensing by community pharmacies)**.

- FP10HP prescription form, **where the prescription will be dispensed by a community pharmacist**. (Note: nurse employers should establish a local policy on the use of prescription forms in these circumstances.)

- Each FP10HP prescription for a hospital based nurse should be stamped:
  a) EXTENDED FORMULARY NURSE PRESCRIBER
  UKCC No ————————
  at the top of the prescribing area (ie. underneath the age/date of birth and patient name address box). The stamp should not be more than 65mm long to avoid stamping the endorsement or Office use columns; and
  b) As follows in the address box:
  Line 1: left justify prescriber or unit name, right justify Organisation Codes Service (OCS) code (R+4 characters)
  Line 2: Hospital name
  Line 3: Hospital address
  Line 4: Address 2
  Line 5: Address 3 right justify: Post Code
  Line 6: Contact telephone number (for community pharmacy use).

The address stamp should be no more than 70mm wide by 28mm depth.

Non-NHS nurses

52 A non-NHS nurse cannot issue an FP10 type out-patient prescription i.e. one which will be dispensed in a NHS community pharmacy, unless the organisation they work for has an arrangement/contract with an NHS provider (e.g. PCT) which allows the non-NHS organisation to use NHS community pharmacy dispensing services. The NHS provider should organise the supply of FP10 type prescription forms (and obtain the prescribing code(s) to be used) for the non-NHS organisation, if this is appropriate.

Re-ordering prescription forms

53 Prescriptions should be re-ordered from Astron as and when required (they are not supplied automatically).

Changes to nurse prescriber details

54 It is the responsibility of employers of nurses working in community trusts, HAs, PCTs, Walk-In Centres or PMS pilots and who are registered with the PPA, to ensure that changes to nurse details are notified to PPA as soon as they occur. Allow at least 5 working days between notifying changes to the PPA and ordering prescriptions for the nurse. This will allow time for data input and transmission of updated data files to Astron. Nurse details on orders must match PPA data held by Astron. If you order too quickly after changing details – the order may be rejected; any orders based on details which conflict with data held by Astron will be rejected.

55 There is currently no requirement to notify the PPA of changes to the details of hospital based nurse prescribers. However the person responsible for hand stamping the nurses details on the prescription form will need to be notified – a new stamp may be required if the details have changed.

How to complete the prescription form

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

57 Nurse and midwife prescribers from the Extended Formulary may *only* prescribe items as specified in the Drug Tariff (Part XVIIB) and documented in the Nurse Prescribers' Extended Formulary (NPEF), as listed in the Drug Tariff and the BNF. A dispenser cannot legally dispense any other item prescribed by a nurse prescriber and any prescription received by the PPA containing such items will not be reimbursed.

58 The NPEF also contains information on the medical conditions or indications for which the items listed may be prescribed. Nurse and midwife prescribers are expected to prescribe in accordance with this information, which forms the basis for their educational preparation, and is the basis on which their employers have agreed to include prescribing in the responsibilities of the post.

59 The nurse prescriber should complete all the details on the front of the prescription form by writing clearly and legibly using an indelible pen (preferably black). The details required are:

- the patient's title, forename, surname and address (including postcode)

- Age and date of birth (when known e.g. from patient notes). NB 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)[9,10] and special containers[11] 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 out-patients 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 out-patients and patients who were being discharged.

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[9] 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.

[10] 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.

[11] 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.

- The names of medicines should be written clearly using approved generic titles (where available) as specified throughout the NPF and NPEF, and should not be abbreviated. **The only exception to this rule is for the prescribing of some dressings and appliances, and of compound or modified release medicines which have no approved non-proprietary name.**

- directions, 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 FP10HP prescriptions only: the nurse's name printed in the box provided (to ensure that the pharmacist is aware who to contact if s/he has a query).

60 Nurses will need to ensure that the prescription is cost effective and meets the clinical needs of the patient. Patients requiring long term treatments should have their clinical management and medical product needs regularly assessed and prescriptions issued should reflect assessed need. For patients with enduring conditions that require continuing medication, dressings or appliances, nurses will need to balance patient convenience with the need to avoid waste of NHS resources and of excessive quantities of medicines in the patients' home. Only sufficient supplies should be prescribed to enable the fulfilment of the care plan, normally up to the re-evaluation date. It is best practice that normally no more than six months should elapse without reassessing the patient's needs.

61 Items that require a doctor's signature should not be entered on a nurse prescription even if they are countersigned by the doctor. A GP prescription must be used at all times when the GP's signature is required.

Role of the pharmacist – advice on medicines

62 Pharmacists are a useful source of help and advice to any prescriber, particularly on matters of pharmacology, drug usage and product selection. They will also know the costs, availability and pack sizes of prescribed items.

63 To enable pharmacists to check whether a nurse prescription handed in for dispensing is bona fide, all NHS employers should keep a list of all nurse prescribers employed by them and the items that the nurse can prescribe. It is also recommended that a copy of the nurse's or midwife's signature is held by the employing authority and individuals should be prepared to provide specimen signatures to pharmacists, should that be required.

64 Community pharmacists will expect to see primary care nurse prescriptions on an FP10P; hospital based nurse prescriptions on an FP10HP. Nurses **must not** use other types of prescription form. See para 47 if you are still using FP10CN or FP10PN.

65 Nurse or midwife prescribers should be aware that pharmacists have legal and ethical obligations which mean they may need to contact prescribers – sometimes urgently – to confirm an aspect of the prescription, return it for amendment or even to refrain from dispensing it (for example if the prescription appears unsafe or contains items which a nurse is not permitted to prescribe). An up to date contact telephone number should be included (in the address box) on all prescriptions.

Security and safe handling of prescription forms: good practice

66 The security of nurse prescription forms is the responsibility of both the employing organisation and the nurse prescriber. It is advisable to hold only minimal stocks of the prescription forms. This reduces the number lost if there is a theft or break-in, and also helps keep prescription forms up to date (they are normally revised annually).

67 The nurse employer should record the serial numbers of prescriptions received and subsequently issued to either an individual prescriber, surgeries, clinics etc.

68 Local policy should be established on monitoring the use of prescription forms to deter the creation of fraudulent prescriptions (see para 107 and 108 re monitoring prescribing).

69 The nurse prescriber should also keep a record of the serial numbers of prescriptions issued to them. The first and last serial numbers of pads should be recorded. It is also good practice to record the number of the first remaining prescription form of an in-use pad at the end of the working day. Such steps will help to identify any prescriptions that are either lost or stolen overnight.

70 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 the desk but placed in a locked drawer. When out visiting, it is advisable for nurses to keep prescription pads in their bags – they should never be left in the car.

71 Best practice recommends that where possible, nurses (especially those working on a sessional or part-time basis) should return all unused forms 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

72 Astron (not the PPA) should be contacted about prescriptions ordered, but not received. The PPA should only be notified if missing items are not found.

73 Practice, community and PMS pilot nurse prescribers should report the loss or theft to the local counter-fraud specialist at the PCT as soon as possible after the theft/loss is confirmed, giving details of the approximate number of scripts stolen, their identification numbers, and where and when they were stolen. The nurse should inform the GP (where appropriate) as soon as he/she is aware of missing scripts.

74 The GP should ensure that the Primary Care Trust has been informed by telephone, as soon as he/she is aware that any prescription forms have been stolen from the nurse in his/her team.

75 In consultation with the regional or national counter-fraud operational teams where appropriate, the PCT/NHS local counter- fraud specialist at the Trust should notify the local pharmacists and decide upon any necessary action to minimise the abuse of the forms. The local counter-fraud specialist at the PCT/NHS Trust should also inform the Compliance Unit at the PPA.

76 Following the reported loss of a prescription form, the PCT/Health Authority will normally tell the prescriber to write and sign all scripts in a particular colour (usually red) for a period of 2 months. The PCT/Health Authority will inform all pharmacies in their area and adjacent PCTs/Health Authorities of the name and address of the prescriber concerned, the approximate number of scripts stolen and the period within which the prescriber will write in a specific colour. This will normally be put in writing within 24 hours with the exception of weekends.

77 In the event of a loss or suspected theft, an NHS Trust-employed nurse should report this immediately to whoever issued the prescription forms (normally the hospital pharmacy). They will inform the local counter fraud specialist at the Trust. The nurse should give details of the number of scripts stolen, their serial numbers, and where and when they were stolen. Thereafter hospital based prescribers should follow local instructions following the loss or theft of prescription forms – this may include writing and signing all scripts in a particular colour (usually red) for a period of two months.

78 It is the responsibility of the employer to ensure that prescription pads are retrieved from nurses or midwives who leave their employment for whatever reason. Prescription pads should be securely destroyed e.g. by shredding and 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 nurses have left employment would still be charged to the appropriate budget.

Good practice, ethics and issues common to all nurse and midwife prescribers

Responsibility for prescribing decisions

79 Nurses qualified to prescribe should not do so on behalf of a nurse who is not a qualified nurse prescriber. A nurse prescriber can only order a drug for a patient whom he/she has assessed for care, and in primary care, should only write prescriptions on a prescription pad bearing his/her own unique identifier number.

80 In the absence of the patient's original nurse prescriber, another nurse prescriber may issue a repeat prescription or order repeat doses following an assessment of need, and taking into consideration continuity of care. Accountability for the prescription rests with the nurse who has issued the prescription or ordered the drugs.

Stock items

81 In primary care settings, nurse prescriptions should not be written when an item has been administered to a patient using GP surgery or clinic stock items, because the cost of these items is already covered through the indirect reimbursement of practice expenses/Trust contracts respectively. The exception is in circumstances where the medical practitioner is eligible for direct reimbursement. These items are listed in paragraph 44.5 of the Statement of Fees and Allowances of NHS General Medical Services (the "Red Book"). When prescribing any of these items for personal administration the prescriber should endorse "PA" on the front of the prescription form. Claims for specified high volume personally administered vaccines must be made as bulk entries on the relevant version of the prescription invoice form FP34 and FP34 (Appendix), following current instructions.

Informing patients

82 Nurse and midwife prescribers must ensure that patients are aware of the scope and limits of nurse prescribing and how the patient or client can obtain other items necessary for their care.

Who to write prescriptions for

83 Practice nurse prescribers may only issue prescriptions for the patients of their own practice. PMS pilot nurses may only issue prescriptions for patients registered to the pilot. Nurses employed by a PCT may only issue prescriptions for the patients of the GP practices within the PCT. In addition, if they are involved in providing services through a Community Nurse Prescribing Contract, they can issue prescriptions for the patients of GP practices covered by the contract and for which a prescribing budget has been agreed. Nurses employed by a Community NHS Trust can only issue prescriptions for the patients of the GP practices covered by the contract and for which a prescribing budget has been agreed. Nurses should only prescribe for the visiting relatives of patients if they are temporarily registered with the doctor concerned. Nurses can prescribe for travelling families, provided that the appropriate residency forms have been completed.

84 Nurses and midwives in secondary care settings can only prescribe for patients in the ward or clinic in which they are working or in their area of clinical responsibility.

Prescribing for self, family and friends

85 Registered nurses and midwives are accountable for their practice at all times, and if a situation arises where they find themselves in a position to prescribe for themselves or their family, then they must accept accountability for that decision. It is strongly recommended that (as for doctors and dentists) nurses should avoid prescribing for themselves or close family members wherever possible, as judgement may be impaired and important clinical examination may be impossible.

Nursing Records

Noting prescribing in the nursing record: good practice

86 All nurses are required to keep contemporaneous records, which are unambiguous and legible. The UKCC Standards for Records and Record Keeping[12] outline the requirements of nurse's records. The record of the nurse's or midwife's prescription should be entered into the nursing patient record (where a separate nursing record exists e.g. in hospitals) at the time of writing. The prescription, together with other details of the consultation with the patient, should be entered into the

[12] Standard for records and record keeping, UKCC 1998

general (GP or hospital) patient record as soon as possible and preferably contemporaneously. It should be marked to indicate that it is a nurse or midwife prescription and should include the name of the 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 should this period exceed 48 hours from writing the prescription. Arrangements for the sharing of all relevant patient records can be put into locally agreed statements of good practice.

87 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 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 also useful, but not mandatory to note advice given on Over The Counter items.

88 In some circumstances, in the clinical judgement of the nurse or midwife prescriber, it may be necessary to advise the GP or consultant immediately of the prescription. This action should be recorded in the nursing records.

Adverse Reaction Reporting

How to report a suspected adverse reaction to a medicine prescribed by a nurse

89 If a patient suffers a suspected adverse reaction to a prescribed, Over The Counter or herbal medicine, it should be reported immediately to the GP or consultant. The Yellow Card Adverse Drug Reaction (ADR) Reporting Scheme is a voluntary scheme through which doctors, dentists, coroners and pharmacists notify the Medicines Control Agency (MCA)/Committee on the Safety of Medicines (CSM) of suspected adverse drug reactions. The MCA/CSM encourage the reporting of all suspected adverse drug reactions to newly licensed medicines that are under intensive monitoring

(identified by a ▼ symbol both on the product information for the drug and in the BNF and MIMS) and all serious suspected adverse drug reactions to all other established drugs. Serious reactions include those that are fatal, life threatening, disabling, incapacitating or which result in or prolong hospitalisation and/or are medically significant. Following pilot studies of ADR reporting by nurses, the MCA is currently exploring the possibility of extending the Scheme to give nurse and midwife prescribers the responsibility to report ADRs directly.

Legal and Clinical Liability

Liability of employer

90 Where a nurse or midwife is appropriately trained and qualified and prescribes as part of their professional duties with the consent of their employer, the employer is held vicariously liable for their actions. In addition, nurse prescribers are individually and professionally accountable to the UKCC for this aspect of their practice, as for any other, and must act at all times in accordance with the UKCC Code of Professional Conduct and Scope of Professional Practice.

Professional indemnity

91 All nurse and midwife 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

92 Where a GP practice is a dispensing practice, nurse and midwife prescriptions can be dispensed by the practice *but only for the dispensing patients of that practice*. Dispensing Doctors cannot dispense prescriptions written by nurses for patients of other practices.

93 When submitting prescriptions to the PPA, dispensing practices should package them in the following way:

- nurses' prescriptions should be sorted by prescriber name
- the nurse prescriptions should then be placed on top of other prescription forms which should be sorted as per existing instructions.

94 Reimbursement for nurse and midwife prescriptions can be claimed by Dispensing Doctors and payment for the prescriptions submitted will be made to the senior partner.

95 If any items dispensed are subsequently found not to be on the Secretary of State's Nurse Prescribers' list as set out in the Drug Tariff/Nurse Prescribers' Extended Formulary, they will not be reimbursed.

Verification of prescribing status

The UKCC Voice Bank

96 Most queries from pharmacists will be resolved by telephoning the prescriber, the prescriber's employer or the PCT (see paras 62-65). However, for general queries about qualification (e.g. in the case of receiving a private prescription), the pharmacist can telephone the 24-hour UKCC Voice Bank system[13]. Pharmacists should clearly state that they are checking the prescribing status of an individual. They should then be asked to give the nurse prescriber's UKCC number and name. If the pharmacist fails to state that he/she is checking prescribing status, the UKCC operator will assume the pharmacist is the nurse's employer and will ask a number of further questions to which the pharmacist will not have the answer.

Role of the pharmacist on verification of prescribing status

97 Pharmacists should ensure that they know the local procedure for contacting a nurse in the event of a query.

98 From April 2002, nurse prescription forms will be overprinted at the top of the prescribing area as either:
DISTRICT NURSE/HEALTH VISITOR PRESCRIBER, **or**
EXTENDED FORMULARY NURSE PRESCRIBER.
For prescriptions marked DISTRICT NURSE/HEALTH VISITOR PRESCRIBER, pharmacists should only dispense items as specified in the district nurse/health visitor formulary. On forms overprinted with EXTENDED FORMULARY NURSE PRESCRIBER, pharmacists may dispense items from either the DN/HV or Extended Formulary.

99 The rules for dispensing and reimbursement of nurse prescriptions are the same as for GP prescriptions.

[13] Telephone number 020 7631 3200

100 Nurse and midwife prescriptions should be sorted by prescriber name. When sorting prescription forms prior to sending them to the PPA for pricing, you should follow the instructions on the Prescription Invoice – Form FP34C. These forms are amended from time to time to reflect changes to prescription forms.

Dispensing by appliance contractors

101 When a nurse becomes aware that the patient intends having a prescription dispensed by an appliance contractor, the nurse must ensure that the prescription does not contain medicinal preparations. Appliance contractors should follow the instructions on the Prescription Invoice – Form FP34A – when sorting prescription forms prior to sending them to the PPA for pricing. *NB Appliance contractors cannot dispense medicinal preparations.*

Urgent dispensing

102 Occasionally a nurse prescription 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. Arrangements for dispensing out of normal hours vary, but details may be available at HAs, PCTs, local pharmacies, NHS Direct or police stations.

Dispensing of items in Wales, Scotland and Northern Ireland

103 Nurse and midwife prescriptions written by nurses in England will only be dispensable by pharmacists in Wales, Scotland and Northern Ireland when the devolved administrations amend their pharmaceutical regulations to permit them to be dispensed on the NHS.

Dispensing items against a nurse prescription in hospital pharmacies

104 See also paragraph 51. An up to date list of all qualified nurse prescribers will need to be kept in the hospital pharmacy. It will be the responsibility of the nurse lead at the NHS Trust to keep this list up to date when circumstances change, e.g. a nurse prescriber leaves her post. Pharmacy staff should, if not known, check that the nurse is a prescriber against the list and that the item prescribed is within the NPEF. The same process will apply for in-patient, out-patient and discharge prescriptions.

Budget Setting and Monitoring

105 The Department of Health has issued detailed guidance to inform all those involved in allocating resources and local budget setting in 2002/3. This amends and updates the guidance for 2001/2 and is placed on three websites:

- PCG/PCT (www.doh.gov.uk/pricare/pcts.htm);
- Finance Manual (www.doh.gov.uk/finman.htm); and
- Prescribing Support Unit (PSU) (www.psu.ppa.nhs.uk).

This guidance is up-dated annually.

Monitoring information – primary care

106 The PPA reimburses costs to dispensing contractors and provide essential monitoring information, both electronically and via paper reports, to authorised users. Information relating to nurse prescribing is available in ePACT.net services, Prescribing Toolkit, PMD, PACT Standard, PACT Nurse Formulary report and the Nurse Formulary Summary report. Nurses can expect to receive information via their HA, PCT or GP Practice which will help to monitor their prescribing. Individual nurse PACT catalogues (giving details down to individual presentation and prescription quantity level) are only available on request. Requests from nurse prescribers should be made on headed notepaper to:-
Prescriber Information
Prescription Pricing Authority
Block B
Scottish Life House
Jesmond
Newcastle upon Tyne
NE2 1DB

Monitoring in secondary care/other settings

107 Prescribing by individual nurses will need to be considered within the context of the clinical team to which they are attached. It may be appropriate to give the senior nurse leading the team the responsibility for monitoring prescribing by nurses within each team.

Evaluation Audit and Clinical Governance of Nurse and Midwife Prescribing

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

109 In addition to the existing (and proposed) central and local systems for monitoring the number and cost of items prescribed by nurse and midwife prescribers, each prescriber is responsible for his/her individual practice, and must carry out regular audits of his/her prescribing practice and take part in the clinical governance activities of their employing organisation.

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

List of Abbreviations

BNF	British National Formulary
DN	District Nurse
ENB	English National Board for Nursing, Midwifery and Health Visiting
ePACT.net	Electronic Prescribing Analysis and Cost Information (on NHS net)
FP10P	District Nurse/Health Visitor prescribing pad (when over-printed DISTRICT NURSE/HEALTH VISITOR PRESCRIBER)
FP10P	Extended Formulary nurse/midwife prescribers' prescribing pad (when over-printed EXTENDED NURSE FORMULARY PRESCRIBER)
HV	Health Visitor
MCA	Medicines Control Agency
NPF	Nurse Prescribers' Formulary
NPEF	Nurse Prescribers' Extended Formulary
PACT	Prescribing Analysis and Cost
PPA	Prescription Pricing Authority
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Annex A1

Notification of Newly Qualified Nurse Prescriber/Change in Circumstances

Use this form to advise details relating to Community NHS Trust Nurse* prescribers. Use only one form per nurse. Nurse prescribers cannot be added to PPA records until all relevant information is provided.

To: PPA, Prescriber Information, Scottish Life House, Archbold Terrace, Jesmond, Newcastle upon Tyne, NE2 1DB

Or email: val.peel@ppa.nhs.uk

From . . . . . .Name of NHS Trust

Please tick applicable box

☐ New Nurse Prescriber – to your organisation
(Complete sections A, B and C1)

☐ Nurse working for additional community unit
(Complete parts A1 and A2, Section B and part C1)

☐ Nurse ending employment at specified community unit
(Complete, as a minimum, parts A1, A2, B1, C2)

☐ Change of surname (Complete section A)

If Nurses UKCC PIN changing please contact
Val Peel on 0191 2035110 or email at the above address

**nurse or midwife prescriber*

Effective start date (to be completed in all cases)			
SECTION A: Nurse prescriber details			
Ref	**Description**	**Details**	
1	Nurse UKCC PIN Number eg 12K3456M		
2	Nurse Name and Initials	Surname	Initials
3	Change of Surname		
4	Title (Mr/Mrs/Miss/Ms/Sister)		
5	Qualified to prescribe from: (please tick only one box)	DN/HV Formulary ☐	Extended Formulary ☐
SECTION B: Community NHS Trust details			
Ref	**Description**	**Details**	
1	Community Nurse Prescribing Contract (CNPC) code e.g. V001		
2	Community NHS Trust address (Headquarters)		
SECTION C: Details of the nurse prescriber in the Community NHS Trust			
Ref	**Description**	**Details**	
1	Start date of Nurse Prescribing within Community NHS Trust/CNPC		
2	End date in community NHS Trust/ CNPC		

Signature: . . . . . .NHS Community Trust Officer

Name: . . . . . .NHS Community Trust Officer

Telephone Number . . . . . .
(Person to contact in case of query)

Annex A2

Notification of Newly Qualified Nurse Prescriber/Change in Circumstances

Use this form to advise details relating to Practice and PMS Pilot Nurse* prescribers. Use only one form per nurse, per practice. Nurse prescribers cannot be added to PPA records until all relevant information is provided.

To: PPA, Prescriber Information, Scottish Life House, Archbold Terrace, Jesmond, Newcastle upon Tyne, NE2 1DB

Or email: val.peel@ppa.nhs.uk

From . . . . . .Health Authority/PCT

Please tick applicable box

☐ New Nurse Prescriber – to your organisation
(Complete sections A, B and C1)

☐ Nurse working for additional practice
(Complete parts A1 and A2, Section B and part C1)

☐ Nurse ending employment at specified practice
(Complete, as a minimum, parts A1, A2, B1, C2)

☐ Change of surname (Complete section A)

If Nurses UKCC PIN changing please contact
Val Peel on 0191 2035110 or email at the above address

**nurse or midwife prescriber*

Effective start date (to be completed in all cases)			
SECTION A: Nurse prescriber details			
Ref	**Description**	**Details**	
1	Nurse UKCC PIN Number eg 12K3456M		
2	Nurse Name and Initials	Surname	Initials
3	Change of Surname		
4	Title (Mr/Mrs/Miss/Ms/Sister)		
5	Qualified to prescribe from: (please tick only one box)	DN/HV Formulary ☐	Extended Formulary ☐
SECTION B: Practice/PMS Pilot details			
Ref	**Description**	**Details**	
1	PPA Practice code or code of Senior GP (state which) e.g. 320010		
2	Practice/Senior GP name		
3	Main surgery address & telephone number		
SECTION C: Details of the nurse prescriber in the practice/PMS pilot			
Ref	**Description**	**Details**	
1	Start date of Nurse prescribing within practice/PMS Pilot		
2	End date in practice/PMS pilot		

Signature: . . . . . .Health Authority/PCT Officer

Name: . . . . . .Health Authority/PCT Officer

Telephone Number . . . . . .
(Person to contact in case of query)

Annex A3

Notification of Newly Qualified Nurse Prescriber/Change in Circumstances

Use this form to advise details relating to Primary Care Trust Nurse* prescribers. Use only one form per nurse. Nurse prescribers cannot be added to PPA records until all relevant information is provided.

To: PPA, Prescriber Information, Scottish Life House, Archbold Terrace, Jesmond, Newcastle upon Tyne, NE2 1DB

Or email: val.peel@ppa.nhs.uk

From . . . . . .Name of Primary Care Trust

Please tick applicable box

☐ New Nurse Prescriber – to your organisation
(Complete sections A, B and C1)

☐ Nurse providing nurse services external to your PCT, through one or more Community Nurse Prescribing Contracts (CNPC).
(Complete parts A1 and A2, Section B and part C1 – use a separate form for each CNPC for which the nurse will prescribe)

☐ Nurse ending employment at PCT/CNPC
(Complete, as a minimum, parts A1, A2, B1, C2)

☐ Change of surname (Complete section A)

If Nurses UKCC PIN changing please contact
Val Peel on 0191 2035110 or email at the above address

**nurse or midwife prescriber*

Effective start date (to be completed in all cases)			
SECTION A: Nurse prescriber details			
Ref	**Description**	**Details**	
1	Nurse UKCC PIN Number eg 12K3456M		
2	Nurse Name and Initials	Surname	Initials
3	Change of Surname		
4	Title (Mr/Mrs/Miss/Ms/Sister)		
5	Qualified to prescribe from: (please tick only one box)	DN/HV Formulary ☐	Extended Formulary ☐
SECTION B: PCT details			
Ref	**Description**	**Details**	
1	PCT code e.g. 5AB12 or CNPC code(s) e.g. V001		
2	PCT/CNPC address (Headquarters)		
SECTION C: Details of the nurse prescriber in the PCT			
Ref	**Description**	**Details**	
1	Start date of Nurse prescribing within PCT		
2	End date in PCT/CNPC		

Signature: . . . . . .PCT Officer

Name: . . . . . .PCT Officer

Telephone Number . . . . . .
(Person to contact in case of query)

Annex B

Policy Statement – Record Keeping

All records created and maintained by health professionals should provide legible, accurate, current, comprehensive and concise information concerning the condition treatment and care of the patient/client and associated observations.

Properly made and maintained records will:

1. Be entered within 48 hours of events to which they relate.

2. If the date of the entry does not coincide with the date of the contact with the patient then the date of the entry, actual time of visit and the date of the contact must be recorded.

3. Be written legibly and indelibly. Each entry must be signed with full signature and dated.

4. Be clear and unambiguous.

5. Be accurate in each entry as to date and time.

6. Alterations must be made by scoring out with a single line. **OTHER FORMS OF ERASURE OR DELETION – SUCH AS THE USE OF CORRECTION FLUID – MUST NEVER BE USED.** The correct entry should then be initialled, dated and timed.

7. Additions to existing entries must be individually dated, timed and signed.

8. All professionally held records must be stored in a secure manner in a locked file, drawer or cupboard.

9. Systems for storing and record keeping will exclude unauthorised access and breaches of confidentiality.

10. Meaningless phrases and offensive subjective statements, unrelated to patient care must not be used.

11. Abbreviations are only acceptable from the previously agreed list.

In Addition:

A. The record of the nurse's prescription must be entered into the patient's records as close as possible to the time of writing the prescription.

B. Where more than one record exists (e.g. a Trust nursing or Walk-in Centre record and the hospital or GP record), information must be entered into each record as soon as possible.

C. The record should clearly indicate the date, the name of the prescriber, the name of the item prescribed, the strength (if any), and the quantity prescribed. In hospitals the date and time of the last dose to be given may be used in place of a quantity to be dispensed. For preparations to be given or taken at a fixed dose or interval, the duration(s) of treatment can be recorded in place of prescribed quantity.

   For medicinal preparations, (items to be ingested or inserted into the body), the dosage schedule and route of administration must be stated, e.g. Paracetamol oral suspension 5 ml 4 hourly.

   For topical medicine preparations, the quantity to be applied and frequency of application must be included.

D. In some circumstances, in the clinical judgement of the nurse prescriber, it may be necessary to advise the patient's doctor immediately of the prescription.

Annex C

Outline Curriculum for the Preparation of Nurses, Midwives and Health Visitors to Prescribe from the Extended Nurse Prescribers' Formulary

This outline curriculum is separate from the preparation of district nurses and health visitors who prescribe from the Nurse Prescribers' Formulary.

ENTRY REQUIREMENTS

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

- valid registration on Parts 1, 3, 5, 8, 10, 11, 12, 13, 14 or 15 of the Professional Register maintained by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting;
- have appropriate experience in the area of practice in which they will be prescribing;
- an ability to study at academic level three;
- support from the employing organisation;
- have a designated medical practitioner who will provide the student with supervision, support and opportunities to develop competence in prescribing practice. (This includes shadowing opportunities).

District nurses and health visitors who prescribe from the Nurse Prescribers' Formulary, and who, with local agreement, will extend their prescribing responsibilities under new arrangements from 2002, must complete this programme of preparation and meet the assessment requirements. It is expected that there will be recognition of prior learning and experience, where appropriate, to avoid duplication of learning.

AIM

The education programme is to prepare nurses, midwives and health visitors to prescribe from the Extended Nurse Prescribers' Formulary as Independent Prescribers.

LEARNING OUTCOMES

The learning outcomes of the programme are at level three and will enable the practitioner to:

- undertake assessment and consultation with patients and carers;
- prescribe safely, appropriately and cost effectively;
- understand the legislation relevant to the practice of nurse prescribing;
- understand and use sources of information, advice and decision support in prescribing practice;
- understand the influences on prescribing practice;
- apply knowledge of drug actions in prescribing practice;
- understand the roles and relationships of others involved in prescribing, supplying and administering medicines;
- practise within a framework of professional accountability and responsibility in relation to nurse prescribing.

INDICATIVE CONTENT

In order to meet the learning outcomes, it is expected that curriculum planning teams will include the following areas of study and develop these into a detailed curriculum which will enable practitioners to develop knowledge and competence as prescribers.

Consultation, Decision-Making and Therapy including Referral

- models of consultation
- accurate assessment, communication and consultation with patients and their carers
- concepts of working diagnosis or best formulation
- development of a management plan
- confirmation of diagnosis – further examination, investigation, referral for diagnosis
- prescribe, not to prescribe, non-drug treatment or referral for treatment

Influences on and Psychology of Prescribing

- patient demand versus patient need
- external influences, for example companies/colleagues
- patient partnership in medicine-taking including awareness of cultural and ethnic needs
- conformance – normalisation of professional prescribing behaviour
- achieving shared understanding and negotiating a plan of action

Prescribing in a Team Context

- national and local guidelines, protocols, policies, decision support systems and formulae – rationale, adherence to and deviation from
- understand the role and functions of other team members
- documentation, with particular reference to communication between team members including electronic prescribing
- auditing, monitoring and evaluating prescribing practice
- interface between multiple prescribers and the management of potential conflict
- budget/cost effectiveness
- issues relating to dispensing practices

Clinical Pharmacology including the Effects of Co-morbidity

- pharmacology including pharmacodynamics and pharmacokinetics
- anatomy and physiology as applied to prescribing practice
- basic principles of drugs to be prescribed – absorption, distribution, metabolism and excretion including adverse drug reactions (ADR), interactions and reactions
- patient compliance and drug response

- impact of physiological state in, for example the elderly, young, pregnant or breast feeding women, on drug responses and safety

Evidence-based Practice and Clinical Governance in relation to Nurse Prescribing

- national and local guidelines, protocols, policies, decision support systems and formulae – rationale, adherence to and deviation from
- continuing professional development – role of self and organisation
- management of change
- risk assessment and risk management, including safe storage, handling and disposal
- clinical supervision
- reflective practice
- critical appraisal skills
- auditing and systems monitoring
- identifying and reporting ADRs and near misses

Legal, Policy and Ethical Aspects

- legal basis, liability and indemnity
- legal implications of advice to self-medicate including the use of complementary therapy and over the counter (OTC) medicines
- safe keeping of prescription pads, action if lost, writing prescriptions and record keeping
- awareness and reporting of fraud
- drug licensing
- yellow card reporting to the Committee on Safety of Medicines (CSM)
- prescribing in the policy context

- manufacturer's guidance relating to literature, licensing and "off-label"
- ethical basis of intervention
- informed consent, with particular reference to client groups in learning disability, mental health, children, the critically ill and emergency situations

Professional Accountability and Responsibility

- UKCC Code of Professional Conduct and Scope of Professional Practice
- accountability and responsibility for assessment, diagnosis and prescribing
- maintaining professional knowledge and competence in relation to prescribing
- accountability and responsibility to the employer

Prescribing in the Public Health Context

- duty to patients and society
- policies regarding the use of antibiotics and vaccines
- inappropriate use of medication including misuse, under- and over-use
- inappropriate prescribing, over- and under-prescribing
- access to health care provisions and medicines

TEACHING, LEARNING AND PRACTICE SUPPORT STRATEGIES

It must be emphasised that self-directed learning and critical reflection are important component parts of the education process. The use of a portfolio or learning log as an effective means of facilitating and recording the student's critical thinking and reflection is well established in professional education.

In addition, the use of random case analysis allows in-depth analysis of treatment scenarios where patient care and prescribing behaviour could be further examined and reflected upon. This approach also provides meaningful feedback to the student, the practice supporter and higher education.

The Board therefore expects these learning approaches to be used in the preparation of nurse prescribers.

The approved higher education institution 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 in particular the achievement of the learning outcomes.

ASSESSMENT STRATEGIES

Competence will be demonstrated through an assessment of theory and practice. To facilitate this each student will maintain a portfolio of assessment and achievement of the stated learning outcomes.

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

A range of assessment strategies will be employed to test knowledge, decision-making and the application of theory to practice. These are:

a) review of portfolio or learning log

b) Objective Structured Clinical Examination (OSCE), a systematic and detailed examination of practice within a simulated learning environment such as a skills laboratory/centre

c) satisfactory completion of the period of practice experience*

d) written final examination consisting of:

   (i) multiple choice questions (MCQ)/short-answer questions – testing knowledge and application

   (ii) essay – testing decision-making and prescribing behaviour

*The assessment of practice will be the responsibility of the prescribing medical practitioner providing support, teaching and supervision of the student.

LENGTH OF THE PROGRAMME

The programme should be 25 days of contact time for the theory component, over a period of three months. In the periods between these study days students are expected to shadow their prescribing medical practitioner for the equivalent of one day per week of educationally led practice. The total length of the programme in both theory and practice is therefore approximately 37 days. It is anticipated that the programme will attract approximately 20 academic credits (CATS points) at level three.

Produced by the Department of Health
14563 2ar 49k Mar 02 (ABB) 26895
CHLORINE FREE PAPER

First Published: March 2002

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